COMMONWEALTH OF VIRGINIA
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

600 East Broad Street, Suite 1300
Richmond, VA 23219

July 1, 2015

Dear Prospective Offeror:

The Department of Medical Assistance Services (DMAS or the Department) is soliciting proposals from qualified firms for the education and enrollment of Medicaid eligible members into the Virginia Medicaid mandatory and voluntary Managed Care Programs. Duties of the Contractor shall include Enrollment Broker and Education Services, along with other enrollment related activities. Specific details about this procurement are in the enclosed Request for Proposal (RFP) 2015-01. The selected contractor will provide the required services for DMAS.

Offerors must check eVA VBO at http://www.eva.virginia.gov for all official addenda or notices regarding this RFP. While DMAS also intends to post such notices on the DMAS website at http://www.dmas.virginia.gov/Content_pgs/rfp.aspx, eVA is the official and controlling posting site. The Commonwealth will not pay any costs that Offerors incur in preparing a proposal. As provided in the Virginia Public Procurement Act, the Department may reject any and all proposals received or cancel this RFP.

Potential Offerors are requested not to call this office. All issues and questions related to this RFP should be submitted in writing to the attention of Scott Cannady, Contract Administrator, Health Care Services Division, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219. In order to expedite the process of submitting inquiries, it is requested that vendors submit any questions or issues by email in MS Word format to RFP2015-01@dmas.virginia.gov no later than 10:00 A.M. EST on July 13, 2015.

Offerors who wish to submit a proposal are required to submit a Letter of Intent (LOI) which must be received by the Department no later than 10:00 AM local time on July 13, 2015. The LOI must be on the Offeror's letterhead and document their intent to submit a proposal in response to the RFP. The prior submission of a LOI is a prerequisite for submitting a proposal; proposals shall not be accepted from Offerors who have not submitted a LOI by the deadline

specified above. LOIs may be emailed to the address listed above with original hard copy to follow via USPS, overnight delivery or courier service. All LOIs shall be addressed to:

Department of Medical Assistance Services
Attention: Christopher Banaszak
600 East Broad Street, Suite 1300
Richmond, VA 23219

Sincerely,

Christopher Banaszak
DMAS Contract Manager

Enclosure

REQUEST FOR PROPOSALS
RFP 2015-01

Issue Date: July 1, 2015

Title: Virginia Medicaid Enrollment Broker and Education Services Contractor

Period of Contract: An initial period of three years from award of contract, with provisions for three (3) twelve-month renewal options.

All inquiries should be directed in writing via email in MS Word Format to: RFP2015-01@dmas.virginia.gov

Scott Cannady, Contract Administrator
Health Care Services Division
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Deadline for submitting Letter of Intent and inquiries: **10:00 AM E.S.T., July 13, 2015**

Proposal Due Date: Proposals will be accepted until **10:00 AM E.S.T. on August 17, 2015**

Submission Method: The proposal(s) must be sealed in an envelope or box and addressed as follows:

" RFP 2015-01 Sealed Proposal"
Department of Medical Assistance Services
Attention: Christopher Banaszak
600 E. Broad Street, Suite 1300
Richmond, Virginia 23219

Facsimile Transmission of the proposal is not acceptable.

Note: This public body does not discriminate against faith-based organizations in accordance with the Code of Virginia, §2.2-4343.1) or against an Offeror because of race, religion, color, sex, national origin, age, disability, or any other basis prohibited by state law relating to discrimination in employment.

In compliance with this Request for Proposal and pursuant to all conditions imposed herein or incorporated by reference, the undersigned proposes and agrees, if awarded this contract, to furnish the services contained in their proposal.

Firm Name (Print)	F.I. or S.S. Number
Address	Print Name
Address	Title
City, State, Zip Code	Signature (Signed in Ink)
Telephone:	Date Signed
Fax Number:	Email:
eVA Registration Vendor Number **Required:**	eVA Vendor #:
State Corporation Commission ID Number **(Required)**: See Special Terms and Conditions	SCC ID #:
Dun & Bradstreet D-U-N-S Number (**Required):**	DUNS#:
Check Applicable Status Corporation ---------- Partnership --------- Proprietorship -------- Individual ------Woman Owned ---------- Minority Owned ---------- Small Business --------- If Department of Small Business and Supplier Diversity (DSBSD) certified, provide certification number:_____	

Submit this completed form with Technical Proposal

COMMONWEALTH OF VIRGINIA

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

REQUEST FOR PROPOSALS

FOR

VIRGINIA MEDICAID ENROLLMENT BROKER AND EDUCATION SERVICES

RFP 2015-01

ISSUED: July 1, 2015

Enrollment Broker and Education Services

1. PURPOSE

The Department of Medical Assistance Services, herein after referred to as "DMAS" or the "Department" is the single state agency in the Commonwealth of Virginia that administers the Medicaid Program authorized under Title XIX of the *Social Security Act*, the Virginia Children's Health Insurance Program, known as FAMIS, under Title XXI of the *Social Security Act* for low income people and the Commonwealth Coordinated Care Program for Medicare and Medicaid dual eligibles. These programs are financed by federal and state funds and administered by the state according to federal guidelines. These programs include coverage of medical services for eligible Medicaid members. Information about the Virginia Medicaid program is available at http://dmasva.dmas.virginia.gov

It is the intent of the Department to solicit proposals from Offerors who wish to contract with the Commonwealth **under a fixed price contractual arrangement as described in this RFP**. Qualified organizations shall be capable of providing the Department with comprehensive Enrollment Broker/Education services which will both educate Medicaid individuals who participate in the MEDALLION 3.0 and Commonwealth Coordinated Care programs about their managed care options and assist Medicaid individuals in enrolling into managed care MCOs/MMPs of their choice. Proposals will be based on the Offeror's responsibilities and proposal submission requirements set forth in this Request for Proposal (RFP). The selected Offeror will provide the services required in this RFP in an efficient and effective manner; within federal, state, and DMAS laws, regulations, and policies and contract requirements ensuring the highest standards of quality performance, program integrity, and advanced and exemplary customer service at a reasonable cost to the Commonwealth. Following evaluations of the proposals received as a result of this RFP, the Department will conduct competitive negotiations.

Number of Awards: An Offeror shall submit a proposal for statewide services only (state of Virginia). The maximum number of contracts to be awarded under this RFP is one.

Duration of Contract: The duration of the contract resulting from this RFP is 3 years from award of contract. The contract will be provided as a **fixed price contract** which may be renewed by the Commonwealth upon written agreement of both parties for up to 3 successive 12-month renewal periods, under the terms of the current contract, and at a reasonable time (approximately 90 days) prior to the expiration date.

General Scope of Responsibilities: The Commonwealth's goal is to operate a highly effective managed care program to serve the health care needs of the individuals who qualify for services. The responsibilities of the Contractor, which are more fully described later in this RFP, include: telephone-based enrollment capabilities; update and maintenance of the Virginia Managed Care and the Commonwealth Coordinated Care (CCC) web sites with ready access to information 24/7, a toll-free call center/helpline providing managed care education and MCO/MMP choices and quality driven customer service; conducting health status assessment surveys on newly

enrolled managed care members; call monitoring, tracking and reporting telephone statistics in support of contract performance and quality standards; creation and revision of MCO comparison charts; and resolution of eligibility, enrollment and complaints. The contractor shall be responsible for call center operations and requirements for both the MEDALLION 3.0 Program and CCC Program, which are described in detail in sections 2 and 3 of this RFP. The MEDALLION 3.0 program and the CCC Program have separate toll free numbers and web sites, which shall be the responsibility of the contractor to operate and maintain. Contract performance standards and contract requirements described in this RFP will apply to both programs unless otherwise specified.

1.1 Implementation Schedule

The Department is seeking an experienced Contractor who can implement Enrollment Broker Services, also known as the Managed Care Helpline, quickly and efficiently. Implementation is the period between date of signing of contract with DMAS and date of start of operations of 1/01/2016.

The Contractor Shall submit, no later than 30 days after the award of the contract, a detailed implementation plan demonstrating the Contractor's proposed schedule to implement Enrollment Broker Services no later than 01/01/2016 and include a dedicated project manager. A comprehensive report on the status of each task, subtask, and deliverable in the work plans shall be provided to the Department by the Contractor every week from the time of contract execution through three months after successful implementation. The implementation plan shall be prepared in Microsoft MS Project and shall delineate each task, with milestones, and dates through the end of the first contract year. The Contractor and Department will work together during initial contract start-up to establish a schedule for key activities and define expectations for the content and format of contract deliverables through the first Fiscal Year.

The Department may make such reasonable investigations as deemed proper and necessary to determine the ability of the Contractor to perform the services and the Contractor shall furnish to the Department all such information and data for this purpose within requested timeframes. The Department reserves the right to inspect Contractor's physical facilities, including any located outside of Richmond, Virginia any time prior to award and anytime during the contract period to satisfy questions regarding the Contractor's capabilities. The Department further reserves the right to reject any proposal if the evidence submitted by, or investigations of, the Contractor fails to satisfy the Department that the Contractor is properly qualified to carry out the obligations of the contract and to provide the required services.

1.2 Definitions

The following terms when used in this RFP shall be construed and/or interpreted as follows, unless the context expressly requires a different construction and/or interpretation.

- **Abandoned Calls**: All calls made to the call center that are ended by the customer before speaking to an agent.
- **Abandoned Call Rate**: The percentage of inbound calls made to the call center that are abandoned by the customer after 60 seconds. It is calculated as abandoned calls divided by total inbound calls (in percent).

- **Administrative Provider Identifier (API)**: A unique 10-digit identification number issued to providers by DMAS. An API number is issued for non-health care (atypical) providers and for providers who do not have an NPI.
- **Adoption Assistance**: A social services program, under Title XX of the Social Security Act, that provides cash assistance and/or social services to adoptive parents who adopt "hard to place" foster care children who were in the custody of a local department of social services or a child placing agency licensed by the Commonwealth of Virginia.
- **Adverse Action:** Consistent with 42 CFR § 438.400, is an action by the Managed Care Organization, subcontractor, service provider, DMAS, or other authorized entity, that constitutes a denial or limited authorization of a service authorization request, including the type or level of service; or reduction, suspension, or termination of a previously authorized service; or failure by the MCO to provide services in a timely manner; or denial in whole or in part of a payment for a covered service; or failure by the MCO to render a decision within the required timeframes; or the denial of an enrollee's request to exercise his right under 42 CFR §438.52(b)(2)(ii) to obtain services outside of the network.
- **Aid Category**: A numerical identifier for the VaMMIS of the covered eligibility group in which the person is enrolled.
- **Annually:** For the purposes of reporting requirements for the contract, resulting from this RFP, annually shall be defined as within 90 calendar days of the effective contract date and effective contract renewal date.
- **Appeal:** In accordance with 42 CFR §438.400, an appeal is a request for review of an action, as "adverse action" is defined in this RFP.
- **Behavioral Health Service Administrator (BHSA):** An entity that manages or directs a behavioral health benefits program on behalf of the program's sponsor. The BHSA is responsible for administering the Department's behavioral health benefits that are currently carved out of managed care on a statewide basis for Title XIX Medicaid individuals and Title XXI FAMIS members to include care coordination, provider management, and reimbursement of such behavioral health services. The BHSA dos not apply to the dual eligibles enrolled in the CCC program.
- **Blockage Rate:** failure to receive a call made to an inbound telephone center because the caller receives a busy signal.
- **Business Days**: Monday through Friday, 8:30 AM to 6:00 PM, Eastern Time, unless otherwise stated.
- **Calendar Year**: January 1 through December 31.
- **Capitated Payment**: A payment the Department makes periodically to a MCO Contractor on behalf of each member enrolled under a contract for the provision of medical services under the State Plan, regardless of whether the particular member receives services during the period covered by the fee.
- **Carved Out Services**: The subset of Medicaid and Medicare covered services for which a MCO plan shall not be responsible under the program.
- **Centers for Medicare and Medicaid Services (CMS):** The Federal agency of the United States Department of Health and Human Services that is responsible for the administration of Title XIX and Title XXI of the Social Security Act.
- **CFR:** Code of Federal Regulations.
- **Choice Counseling:** As defined by CMS, this includes activities such as answering questions and providing information (in an unbiased manner) on available MCO options, and advising on what factors to consider when choosing among them.

- **Claim:** An itemized **s**tatement of services rendered by health care providers (such as hospitals, physicians, dentists, etc.), billed electronically or on the CMS 1500 or UB-92
- **Client, Enrollee, Member, Recipient, or Participant**: an individual enrolled in Medicaid or Medicaid and Medicare (dual eligible) who is required to participate or who is participating in a DMAS managed care program.
- **Commonwealth Coordinated Care (CCC) Program:** A managed care program that coordinates care for individuals who are currently served by both full Medicare (entitled to benefits under Medicare Part A and enrolled under Medicare Parts B and D) and full Medicaid and meet certain eligibility requirements. This program is designed to be the single entity accountable for coordinating delivery of eligibility requirements, delivery of primary, preventative, acute, behavioral, and long-term care services and supports.
- **Complaint:** A grievance.
- **Contract Modification:** Any change or modification to the Contract that are mutually agreed to in writing by the Contractor and the Department or are mandated by changes in federal or state laws or regulations.
- **Contract:** The signed and executed document resulting from this RFP, which includes the terms of this RFP. The Contract shall also include the RFP, the winning Offeror's proposal and any modifications to the Contract.
- **Contractor:** For the purposes of this RFP, the Enrollment Broker that has entered into an agreement with the Department to provide enrollment and education services under a fixed-price contractual arrangement.
- **FAMIS:** Virginia Child Health Insurance Program, known as "Family Access to Medical Insurance Security" or "FAMIS" under Title XXI of the *Social Security Act*.
- **Covered Service:** Medically necessary medical services reimbursed through MCOs for Medicaid individuals.
- **Cultural Competency:** A competency based on the premise of respect for individuals and cultural differences, and an implementation of a trust-promoting method of inquiry and assistance.
- **Days:** Business days, unless otherwise specified.
- **Department:** The Virginia Department of Medical Assistance Services (or DMAS).
- **Disenrollment:** The discontinuance of a member's eligibility to receive covered services under the terms of this RFP, and deletion from the approved list of members furnished by the Department to the Contractor.
- **Dual Eligible:** A Medicare beneficiary who receives Medicare Part A, B, and D benefits and who also receives full Medicaid benefits.
- **Eligible Person:** Any person certified by the Department as eligible to receive services and benefits under the Department's Programs.
- **Encryption:** A security measure involving the conversion of data into a format that cannot be interpreted by unauthorized parties.
- **Enrollee:** A individual who has Medicaid, FAMIS or Medicare and Medicaid (dual eligible) and who has been assigned to an MCO participating in MEDALLION 3.0 or the CCC program.
- **Enrollment:** The determination by local Department of Social Services of an individual's eligibility for Medicaid or FAMIS and subsequent entry into the Virginia Medicaid Management Information System (VaMMIS).
- **Enrollment Activities:** Activities such as distributing, collecting, and processing enrollment materials and taking enrollments by mail, phone, or person, as further described in Section 3.

- **Enrollment Area:** The counties and municipalities in which an eligible organization is authorized by the Commonwealth of Virginia, pursuant to a Contract, to operate and in which service capability exists as defined by the Commonwealth.
- **Enrollment Broker:** An independent entity that performs choice counseling, education and enrollment activities through the operation of a toll-free member service helpline in accordance with 42 CFR §438.810 and as detailed in Sections 3 and 4 of this RFP.
- **Enrollment Period:** The time that a member is enrolled in a Department approved MCO during which they may not disenroll or change MCOs unless disenrolled under one of the conditions described in Section 3 pursuant with Section 1932 (a)(4)(A) of Title XIX or under the conditions specific to the CCC program.
- **Enrollment Services:** Choice counseling, education and enrollment activities as detailed in Section 3.
- **EPSDT:** The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program is Medicaid's comprehensive and preventive child health program for individuals under the age of 21. EPSDT was defined by law as part of the Omnibus Budget Reconciliation Act of 1989 (OBRA 89) legislation and includes periodic screening, vision, dental and hearing services. In addition, section 1905(r)(5) of the Social Security Act (the Act) requires that any medically necessary health care service listed at section 1905(a) of the Act be provided to an EPSDT member even if the service is not available under the state's Medicaid plan to the rest of the Medicaid population.
- **E-Verify System**: A federal internet-based data system that compares I-9 Form information, presented by a new employee, to data from the U.S. Department of Homeland Security and Social Security Administration records. It is used to confirm that the employee is legally eligible to work in the United States.
- **Exclusion:** The removal of an enrollee from a program on a temporary or permanent basis.
- **Expedited Appeal:** The process by which an MCO must respond to an appeal by an enrollee if a denial of care decision may jeopardize life, health or ability to attain, maintain or regain maximum function.
- **FAMIS Enrollee:** Persons enrolled in the Department's "FAMIS" program who are eligible to receive services under the State Child Health Plan under Title XXI, as amended.
- **Fee-for-Service:** The Department's traditional health care payment system in which physicians and other providers receive a payment for each unit of service they provide.
- **Federal Information Processing Standards Codes (FIPS):** A standardized set of numeric or alphabetic codes issued by the National Institute of Standards and Technology (NIST) to ensure uniform identification of geographic entities through all federal government agencies. The entities covered include: states and statistically equivalent entities, counties and statistically equivalent entities, named populated and related location entities (such as, places and county subdivisions), and American Indian and Alaska Native areas.
- **Fiscal Agent:** A contracting organization that assumes all or part of the State Medicaid Agency's responsibilities with respect to claims processing, provider enrollment and relations, utilization review, and other functions. This is synonymous with Fiscal Intermediary.
- **Fiscal Year (State):** July 1 through June 30.
- **Foster Care (FC):** Pursuant to 45 CFR §1355.20, a 24-hour substitute care for children placed away from their parents or guardians and for whom the state agency has placement and care responsibility". Transfer of the legal custody of the child is not a component when determining if a child is considered to be in foster care. The federal definition is predicated

upon the child being placed outside of the home and with an individual who has "placement and care" responsibility for the child. The term "placement and care" means that LDSS is legally accountable for the day-to-day care and protection of the child through either a court order or a voluntary placement agreement. If a child is placed outside of the home and LDSS is the case manager with placement and care responsibility, then the federal government considers the child to be in foster care.

- **FTE:** Full time equivalent employment position.
- **Fraud:** Intentional deception or misrepresentation made by a person or entity with the knowledge that the deception could result in payment of an unauthorized benefit. Fraud also includes any act that constitutes fraud under applicable federal or state law.
- **Grievance:** In accordance with 42 CFR §438.400, grievance means an expression of dissatisfaction about any matter other than an "adverse action." Grievance is also used to refer to the overall system that includes grievances and appeals handled at the MCO level. Possible subjects for grievances include, but are not limited to, the quality of care or services provided and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights.
- **Health Insurance Portability & Accountability Act of 1996 (HIPAA):** Title II of HIPAA, as amended, requires standardization of electronic patient health, administrative and financial data; unique health identifiers for individuals, employers, health plans, and health care facilities, and security standards protecting the confidentiality and integrity of individually identifiable health information past, present, or future.
- **Health Plan:** Managed Care Organization (MCO).
- **Health Status Survey and Assessment Tool (HSA or Health Status Survey):** a health questionare given to MEDALLION 3.0 members by call center staff and provided to participating MEDALLION 3.0 plans (attachment VI)
- **Home and Community-Based Care Services (HCBS**): Medicaid community-based care programs operating in the Commonwealth under the authority of 1915(c) of the Social Security Act, 42 U.S.C. §1396 including, but not limited to, the waivers for Elderly or Disabled with Consumer Directed Services, Intellectual Disability, Alzheimer's Assisted Living, Technology Assisted, Individual and Family Developmental Disabilities Support, and Day Support.
- **Implementation Date:** The effective date of the contract.
- **Informational Materials:** Written communications to enrollees that educates and informs about services, policies, procedures, or programs relating to DMAS managed care programs.
- **Initial Implementation:** The first time a program or a program change is instituted in a geographical area by the Department.
- **Inquiry:** An oral or written communication by or on the behalf of a member that may be: 1) questions regarding the need for additional information about eligibility, benefits, plan requirement or materials received, etc; 2) provision of information regarding a change in the member's status such as address, etc.; 3) a request for assistance such as selecting or changing MCO, obtaining translation or transportation assistance, obtaining access to care, etc. Inquiries are not expressions of dissatisfaction.
- **List of Excluded Individuals and Entities (LEIE)**: A federal database maintained by the Office of the Inspector General in the Department of Health and Human Services containing the names of persons and entities excluded from participation in federally financed healthcare programs by the authority granted in 42 USCA §1320a-7.

- **Managed Care Organization (MCO):** An organization that has an executed agreement with the Virginia Department of Health that offers managed care health insurance plans (MCHIP), as defined by Virginia Code § 38.2-5800, (an arrangement for the delivery of health care in which a health carrier undertakes to provide, arrange for, pay for, or reimburse any of the costs of health care services). For the purposes of this Contract, and in accordance with 42 CFR §438.2 and any other relevant federal and state law and regulations, means an entity that has qualified to provide the services covered to qualifying Medicaid members and dually eligible members who quality for the CCC program within the area served, and meets the solvency standards of 42 CFR §438.116, and any other relevant federal and state laws and regulations.
- **Medicaid Individual**: An individual having Medicaid coverage, who is eligible to participate in the MEDALLION 3.0 program or an individual having Medicaid coverage who is dually eligible for both Medicare and Medicaid and is eligible to participate in the Commonwealth Care Coordination Program (CCC). When this definition is used in this RFP, the program in which the Medicaid individual is eligible for will be specified.
- **Marketing Materials:** Materials that are produced by or on behalf of an MCO; are used by the MCO to communicate with individuals who are not its enrollees; and can reasonably be interpreted as intended to influence the individuals to enroll or reenroll in that particular MCO and entity.
- **Medallion 3.0 Program:** A fully capitated, risk-based, mandatory Medicaid managed care program in which qualified Medicaid individuals choose between at least two contracted Managed Care Organizations. The contracted MCO receives a capitated PMPM payment that covers a comprehensive set of services, regardless of how much care is used by the member.
- **Medicaid Fraud Control Unit (MFCU):** The unit established within the Office of the Attorney General to audit and investigate providers of services furnished under the Virginia State Plan for Medical Assistance, as provided for in the Code of Virginia § 32.1-320, as amended.
- **Medicaid Management Information System (MMIS)**: The medical assistance eligibility, enrollment and payment information system of the Virginia Department of Medical Assistance Services (also referred to as VaMMIS).
- **Medicaid/Medicare Plans (MMPs)**: managed health care organizations who participate in the CCC program
- **Monthly:** For the purposes of reporting requirements, monthly shall be defined as the 15th day of each month for the prior month's reporting period. For example, January's monthly reports are due by February 15th; February's are due by March 15th, etc.
- **National Provider Identifier (NPI)** - A unique 10-digit identification number issued to health care providers in the United States by the Centers for Medicare and Medicaid Services (CMS). All individual HIPAA covered healthcare providers or organizations must obtain an NPI for use in all HIPAA standard transactions, even if a billing agency prepares the transaction.
- **Network Provider**: The health care entity or health care professional that is either employed by or has executed a provider agreement with the Department through the Contractor, or its subcontractor, to render covered services, as defined in this Contract.
- **Offeror:** The entity that seeks to contract with the Department and submits a proposal in response to this RFP.
- **Open Enrollment:** The time frame in which members are allowed to change from one MCO

to another, without cause.

- **Opt Out:** Opt Out – Cancellation is when an enrollee cancels a request to enroll or before the effective date of enrollment. Opt-Out – Disenrollment is when the enrollee is actively receiving services from the MMP or after the effective date of enrollment.
- **Performance Penalties:** A dollar amount stipulated in this contract and determined by DMAS that would be owed to DMAS in the event of a breach by the contractor of contract deliverables or failure to meet contract performance standards.
- **Potential Medicaid Individual**: A Medicaid individual who is subject to mandatory enrollment in the MEDALLION 3.0 managed care program.
- **Primary Care Provider (PCP):** A practitioner who provides preventive and primary medical care for eligible members and who certifies prior authorizations and referrals for all medically necessary specialty services. PCPs may include pediatricians, family and general practitioners, internists, obstetrician/gynecologists, and specialists who perform primary care functions such as surgeons, clinics including, but not limited to, health departments, Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (FHCs), etc.
- **Program Integrity Plan:** Written Fraud and Abuse Compliance Plan to adequately identify and report suspected fraud and abuse.
- **Protected Health Information (PHI):** Individually identifiable patient information, including demographics, which relates to a person's health, health care, or payment for health care. HIPAA protects individually identifiable health information transmitted or maintained in any form or medium.
- **Quarterly:** For the purposes of reporting requirements, quarterly shall be defined as within 30 calendar days after the end of each quarter, unless otherwise specified by the Department.
- **Quarters:** Calendar quarters starting on January 1, April 1, July 1, and October 1.
- **Referral:** A request by a provider for a member to be evaluated and/or treated by a different physician, usually a specialist.
- **Richmond Virginia Metropolitan Area:** the Richmond Virginia Metropolitan area is defined as the City of Richmond and the counties of Chesterfield, Henrico and Hanover Virginia.
- **Secure email:** The generic term that usually applies to sensitive email being passed over the Internet in some form of encrypted format.
- **Services:** See covered service.
- **Service Authorization:** The act of authorizing specific services or activities before they are rendered or activities before they occur (formerly called prior authorization).
- **Shall:** A mandatory requirement or a condition to be met.
- **State:** Commonwealth of Virginia.
- **State Fair Hearing:** The Department of Medical Assistance Services' evidentiary hearing process. Adverse actions may be appealed by the enrollee to the Department of Medical Assistance Services' Appeals Division before, during or after an enrollee appeals to the MCO. The Department conducts evidentiary hearings in accordance with regulations at 42 CFR § 431, Subpart E, 12 VAC30-110-10 through 12VAC30-110-370, and § 2.2-4027 et seq. of the Virginia Code
- **State Plan for Medical Assistance (State Plan)**: The comprehensive written statement submitted by the Department to CMS for approval, describing the nature and scope of the Virginia Medicaid program and giving assurance that it will be administered in conformity with the requirements, standards, procedures and conditions for obtaining Federal financial

participation. The Department has the authority to administer the State Plan for Virginia under Code of Virginia § 32.1-325, as amended.

- **Subcontractor:** Any DMAS approved organization or person who provides any function or service for the Contractor specifically related to securing or fulfilling the Contractor's obligations to the Department under the terms of this RFP.
- **Third Party Liability (TPL):** The legal obligation of third parties, i.e., certain individuals, entities, or programs, to pay all or part of the expenditures for medical assistance furnished under the State Plan.
- **Vendor:** One who sells goods or services.
- **Virginia Administrative Code (VAC):** Contains regulations of all of the Virginia State Agencies.
- **Virginia Medicaid Management Information System (VaMMIS):** The medical assistance eligibility, enrollment, and payment information system of the Virginia Department of Medical Assistance Services.
- **Virginia Medicaid Policy:** Includes the State plan, waivers, regulations, manuals and Medicaid memoranda.

1.3 Acronyms

BHSA – Behavioral Health Services Administrator

CCC – Commonwealth Coordinated Care (Medicare-Medicaid Financial Alignment)
CFR. -- Code of Federal Regulations
CMS -- Centers for Medicare and Medicaid Services

DMAS -- Department of Medical Assistance Services
DME -- Durable Medical Equipment
DSBSD – Department of Small Business and Supplier Diversity
DSS -- Department of Social Services

EDCD -- Elderly or Disabled with Consumer Direction
EOC -- Evidence of Coverage
EOM -- End of Month
EPSDT -- Early Periodic Screening, Diagnosis, and Treatment

FIPS -- Federal Information Processing Standards
FQHC -- Federally Qualified Health Centers
FTP -- File Transfer Protocol

HIPAA -- Health Insurance Portability and Accountability Act of 1996, as amended
HIV/AIDS -- Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome

LEIE – List of Excluded Individuals and Entities
LIFC - - Low Income Families and Children

MCO -- Managed Care Organization
VaMMIS/MMIS – Virginia Medicaid Management Information System

NPI -- National Provider Identifier

OIG – Office of Inspector General

Part C -- Part C of the Individuals with Disability and Education Act (also known as Early Intervention)
PCCM -- Primary Care Case Management
PCP -- Primary Care Provider
PHI -- Protected Health Information

RFP -- Request For Proposal
RHC -- Rural Health Clinics

TPL -- Third-Party Liability

VAC -- Virginia Administrative Code

2. BACKGROUND

DMAS operates two programs that require enrollment broker services that will be administered by the offerer under the terms of this proposal, the MEDALLION 3.0 Program and the CCC Program. Unless otherwise specified, all of the requirements stipulated in this RFP apply to both programs.

2.1 MEDALLION 3.0 Program

The Department currently operates one Medicaid mandatory managed care program: named Medallion 3.0, a program that delivers complete medical care through six (6) managed care organizations (MCOs) under contract with the Department. The mandatory managed care program operates under a Centers for Medicare and Medicaid Services (CMS) 1915(b) Waiver and in accordance with federal and state Regulations. For general information about the waiver: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html

There are some individuals who are excluded from participating in managed care. These individuals are covered under the fee-for-service program. Examples of managed care excluded individuals include, but are not limited to, individuals who reside in a state mental institution, and individuals with other primary insurance. Information about exclusions is located at http://www.dmas.virginia.gov/Content_atchs/mc/mc-mdl2_exlsns.pdf.

The Medallion 3.0 program is a fully capitated, risk-based, mandatory managed care program for Medicaid individuals. In all areas of the Commonwealth (134 localities), qualified Medicaid individuals choose between at least two contracted Managed Care Organizations (MCOs) in their locality. More information about the history of managed care in Virginia is available on the DMAS Website at http://www.dmas.virginia.gov/Content_atchs/mc/mc-hstry.pdf.

Under Medallion 3.0, the contracted MCO receives a capitated PMPM payment each month that covers a comprehensive set of services, regardless of how much care is used by the member. The MCOs accept full financial risk for each member's health care. This monthly payment includes all covered contract services. There are some individuals who are excluded from participating in

Medallion 3.0, even if they reside in a Medallion 3.0 region. These individuals are covered under the FFS fee-for-service program. There are certain services that are "carved out" of the Medallion 3.0 contract and reimbursed through the Department's fee-for-service program. These services include, but are not limited to, community mental health rehabilitative services, certain substance abuse treatment services, dental services, and nutritional supplements for children under age 21. The complete list of managed care excluded populations is provided in state regulation at 12VAC30-120-370.

The fee-for-service and managed care delivery systems are structured to manage the growing Medicaid member population. The following table illustrates the change in the MEDALLION 3.0 population by region over a 13 month period ending in February of 2015:

Month	CNVA	FSWV	HALF	LSWV	NOVA	TIDW	USWV	Total
FEB 2014	166,583	46,180	38,003	64,396	136,248	146,343	38,172	635,925
MAR 2014	165,978	45,892	37,956	64,641	137,074	145,350	39,270	636,161
APR 2014	163,849	45,492	38,462	64,314	136,661	144,923	39,234	632,935
MAY 2014	165,417	45,473	38,392	65,778	137,978	145,550	39,565	638,153
JUN 2014	167,663	46,551	38,651	65,973	139,879	146,304	39,996	645,017
JUL 2014	168,935	45,867	38,648	65,729	141,575	143,851	40,115	644,720
AUG 2014	170,299	45,701	38,630	65,524	141,309	142,812	39,988	644,263
SEP 2014	176,621	47,142	39,709	67,421	141,480	145,635	41,377	659,385
OCT 2014	178,926	47,741	39,676	67,756	143,196	146,007	41,301	664,603
NOV 2014	181,432	47,941	39,450	68,442	143,030	147,221	40,998	668,514
DEC 2014	182,742	48,444	40,075	68,700	143,486	148,906	41,667	674,020
JAN 2015	182,896	48,379	40,080	68,556	143,004	148,651	41,371	672,937
FEB 2015	183,547	48,156	40,205	68,022	144,276	148,959	41,496	674,661

*CNVA- Central Virginia, FSWV – Far Southwest Virginia, HALF – Halifax Region, LSWV – Lower Southwest Virginia, NOVA – Northern Virginia, USWA – Upper Southwest Virginia

Effective March 2015, 1,057,996 individuals were enrolled in the Medicaid program. Medicaid individuals in the eligibility aid categories of Aged, Blind, Disabled, and Low Income Families with Children (LIFC), with a few exceptions, are required to enroll into a Medicaid Managed Care program. Managed Care participation by program is reflected in the MCO Plan enrollment changes for calendar year 2014 in Attachment XIII. The following table identifies the MCOs currently contracted with the Department, the number of members in each respective health plan, and the geographical areas served by health plan. The six areas also known as regions are Central Virginia, Tidewater, Northern and Winchester, Western, Roanoke/Alleghany and Far Southwest.

Health Plan Participation by County

Health Plan	Number of Cities/Localities	Medicaid Plan Enrollment as of May 2015
INTotal Health(formerly known as Amerigroup)	11 (Northern Virginia)	53.778
Anthem Healthkeepers Plus, Peninsula and Priority Offered by Healthkeepers, Inc.	134 (Central Virginia, Charlottesville, Halifax, Northern Virginia, Tidewater, and Winchester)	257,199

Optima Family Care A Service of Sentara	80 (Central Virginia, Charlottesville, Halifax, Lynchburg, Tidewater, and Winchester)	163,833
CoventryCares of Virginia	34 (Central Virginia and Lynchburg)	39,006
Virginia Premier Health Plan. Inc.	91 (Central VA, Charlottesville, Halifax, Southwest, Lynchburg, Northern Virginia, Tidewater, and Winchester)	178,069
Kaiser Permanente	10 Alexandria, Arlington, Fairfax City, Fairfax County, Falls Church, Loudon, Manassas, Manassas Park, Prince William	163,069

Attachment XXVI of this RFP provides enrollment projections for the MEDALLION 3.0 Program and the CCC Program from the period of January 2015 through December of 2018.

MEDALLION 3.0 Participation for Enrollees in the Home and Community Based (HCBS) Waiver

Individuals enrolled in the Elderly or Disabled with Consumer Direction (EDCD) waiver are eligible for managed care participation (MEDALLION 3.0 enrollment) as long as they have no other exclusion reason(s). MCO enrolled individuals who subsequently become enrolled in the Intellectual Disabilities (ID) Waiver, the Day Support (DS) Waiver, the Alzheimer's Assisted Living (AAL) Waiver, the Individual and Families Disability Support (DD) Waiver, (except for the Technology Assisted Waiver) remain enrolled in their assigned MCO for medical services and transportation to medical appointments. The individual's HCB services (including transportation to HCB services) are managed and paid for under the Department's fee-for-service program. MCO individuals who become enrolled in the Technology Assisted Waiver continue to be disenrolled from the MCO, and remain covered under the fee-for-service program for acute and waiver services.

MEDALLION 3.0 Participation for Enrollees in Foster Care and Adoption Assistance

The Department of Medical Assistance Services (DMAS) received permission from the Governor and the General Assembly to transition foster care and adoption assistance children into managed care health plans versus remaining in fee for service Medicaid (MEDALLION 3.0 Program). Statewide implementation for eligible children in foster care or receiving adoption assistance was completed in June 2014. Foster Care and Adoption Assistance members can make plan changes monthly and do not have to wait until the open enrollment period. Authorized DSS staff can also make plan changes for Foster care members. Adoptive parents can make plan changes for their adoptive children.

2.2 The Commonwealth Coordinated Care (CCC) Program

The CCC Program was announced by the Centers for Medicare & Medicaid Services (CMS) in 2011 to help streamline service delivery, improve health outcomes, and enhance the quality of life for individuals eligible for both Medicare and Medicaid services ("dual eligibles") and their families. Under the CCC's capitated model, DMAS, CMS, and selected managed care organizations (MCOs) entered into three-way contracts through which the MCOs receive a blended capitated rate for the full continuum of Medicare and Medicaid benefits provided to dual eligible individuals. Virginia

implemented the CCC program in January, 2014, and the demonstration is scheduled to run through December, 2017.

DMAS implemented the CCC program in five (5) regions (Central Virginia, Northern Virginia, Tidewater, Western/Charlottesville, and Roanoke) starting in 2014. Implementation will be phased-in. Eligible individuals age 21 and over who are enrolled in Medicare Parts A and B and full-benefit Medicaid, including those enrolled in the Elderly or Disabled with Consumer Direction (EDCD) Waiver and those residing in nursing facilities will be eligible to participate in the program. Approximately, 70,000 dual eligible individuals may be eligible to enroll and participate in the first year of the program. This means that dual eligible individuals who participate in the CCC program will receive their primary, acute, behavioral and long-term care services through a network of providers maintained by the MCOs and no longer through providers in the Medicaid fee for service system. Participation in the CCC program by eligible individuals is voluntary. Eligible individuals are passively enrolled, but they may opt out at any time before or during the program period. **As of March 2015, there are 63,729 eligible CCC members.** The table below identifies CCC eligible members, who are active opt-ins, passive opt-ins, and opt-outs as of March 14, 2015:

CCC Member Participation By Region - Mar 14, 2015			
CCC_Region	**Active Opt-ins**	**Passive Opt-ins**	**Opt-outs**
Central Virginia	1939	8014	9603
Northern Virginia	264	1244	1791
Roanoke	610	4273	4031
Tidewater	1650	6884	8336
Western/Charlottesville	412	2193	2403
Total Members	**4875**	**22608**	**26164**

Visit DMAS' Integrated Care for Medicare-Medicaid Enrollees website at http://www.dmas.virginia.gov/Content_pgs/altc-enrl.aspx and the CCC program web site at http://www.virginiaccc.com for additional information about the Program in Virginia. Updates regarding the status of this Demonstration will be posted to the website on a regular basis.

Effective as of March, 2015, there are currently three (3) MCO plans participating in the CCC program:

1. Anthem Healthkeepers MMP
2. Virginia Premier MMP
3. Humana Gold Plus Integrated

The areas they serve by city/county and region of the Commonwealth for CCC eligibles are located at http://virginiaccc.com/English/enrolling.html#city. The operational requirements specific to the CCC Program are described in Section 3.41 of this RFP. All contract requirements and performance standards in this RFP apply to both the MEDALLION 3.0 Program and the CCC Program, unless otherwise specified.

2.3 Enrollment Process

The Department and the selected Contractor will be responsible for conducting all enrollment and education activities for Medicaid managed care eligible members participating in the Medallion 3.0 Program and the CCC program. The selected Contractor will facilitate enrollment and education services for the required populations and programs as the programs expand, the population changes, and/or geographical regions change. Additional information regarding enrollment processes is more fully described in Section 3 of this RFP.

2.4 Enrollment Mailings

Enrollment mailings are sent by the Department, through its contracted mailing vendor, and include assignment and open enrollment letter mailings. All assignment packages include a selection letter, an MCO brochure and an MCO Comparison Chart. The Contractor shall be responsible for developing, printing and maintaining an inventory of the managed care materials and the costs associated with these functions. DMAS will approve any changes that are made to the comparison charts and brochures. Current Medicaid MCO documents can be viewed at http://www.dmas.virginia.gov/Content_pgs/mc-home.aspx. CCC documents can be viewed at http://www.virginiaccc.com/English/charts.html

2.5 Role of Enrollment Broker

The Department currently has a contract to assist Medicaid managed care eligible members in choosing and enrolling into a managed care plan of their choice. The Contractor, selected as a result of this RFP, shall have multiple functions and responsibilities including but not limited to:

- Providing MCO/MMP selection information to members to assist them in choosing a managed care health plan available in their region. This includes providing basic education on managed care and preventive health care. ***Representatives of the Contractor shall not be allowed or shall not participate in recommending one health plan over another.*** A customized script shall be developed for staff to assist them in offering MCO/MMP choices for each region if applicable.
- Operating a comprehensive toll-free telephone call center during normal business hours 8:30 am to 6:00 pm Eastern Standard Time, except state holidays, staffed with trained individuals capable of accurately responding to member concerns; providing member education; and handling a variety of enrollment activities.
- Providing a sufficient number of properly functioning toll-free Voice and Telecommunication Devices for the Deaf or a dedicated (TDD/TTY) telephone number/line (in-state and out-of-state) for parties to call for services described in this RFP. The Virginia Relay Service for the Deaf and Hard-of-Hearing must be used when appropriate.
- Providing translation services via telephone for members requiring assistance in languages other than English.
- Operating an overflow call center.
- Operating a dedicated, automated tracking and reporting system for Medicaid managed care program inquiries by aid category or program; i.e. Foster Care and Adoption Assistance, CCC program, etc.
- Providing specific information about each health plan such as the plan's network of providers

including physicians by specialty, hospitals, etc. and their specific location, service area and contact information

- Resolving complaints and inquiries, including forwarding them to the appropriate entity for resolution. For clinical complaints of an urgent nature or complaints the Contractor is not able to resolve, the Contractor shall refer the complaint immediately to the Department's Contract Administrator and record these complaints on a weekly grievance report.
- Developing and implementing a secure HIPAA compliant, web-based issue and complaint resolution tracking software that that can be accessed by enrollment contractor staff, DMAS staff, and MCO/MMP staff via a secure connection to close the loop on member complaints received through the call center. This tracking software shall generate a complaint log/report referenced as a reporting requirement in this RFP.
- Providing thorough prescreening of demographic information and verification of eligibility information for callers.
- Interfacing with the Virginia Medicaid Management Information System (VaMMIS) per requirements described in this RFP.
- Creating and administering the Health Status Survey and Assessment Tool (HSA or Health Status Survey) for Medicaid individuals eligible for the MEDALLION 3.0 program, upon new enrollment and/or when changes are made to enrollment, to determine the health status of the member, any on-going treatments, pre-authorized services, or authorized durable medical equipment currently utilized by the member which would necessitate coordination of care on the part of the MCO. A significant piece of information to obtain is a current, valid phone number for the member which is critical for transition of care contact for the MCOs. Forward assessments to participating MCOs and other DMAS contractors each week.
- Triaging member calls to participating MCO/MMP Customer Service departments, local DSS agencies, or the Department's Recipient and Provider Help Lines, or the Department's managed care staff and CCC staff.
- Developing and maintaining member materials including regional comparison charts and managed care brochures for MCO programs as described in Section 3 of this RFP.
- Reporting call center statistics on performance and other areas as described in Sections 3 and 4 of this RFP.
- Developing and implementing activities toward continuous quality improvement of customer service and enrollment functions.
- Developing and maintaining a website owned and controlled by DMAS (www.virginiamanagedcare.com and www.virginiaccc.com) with interactive features, including links to plan comparison charts and all educational materials identified in this RFP.
- Providing the full scope of services described in Sections 3 and 4 of this RFP including services for expansion of different covered groups (such as Foster Care) and/or geographic expansions.
- Developing and implementing a Customer Service Satisfaction Survey that evaluates customer experience and quality of service; reporting results monthly.

3. REQUIREMENTS AND TECHNICAL PROPOSAL

This section contains the contractual requirements and functional description for education and enrollment in managed care plans. At a minimum, the following components must be addressed. The following methodology suggests a protocol and structure for the education and enrollment process.

However, the Department may consider alternative approaches for achieving the requirements described.

3.1 Overview and Regulatory Requirements

The primary roles of the Contractor are to ensure that the managed care population receives timely, accurate and comprehensive information and education about Managed Care Programs; and to perform all functions directly related to the enrollment of members into the health plan of their choice. In accordance with Title 42 of the *Code of Federal Regulations* (CFR), Section 438, part 810, Contractor activities shall be delivered by an external entity with no corporate connections or financial interest in any of the Virginia contracted MCOs/MMPs. As part of its technical proposal, the Offeror shall provide a statement attesting to their freedom from conflict of interest, as well as full compliance with enrollment broker related activities, in accordance with Federal Regulations and as detailed in Attachment X.

The Contractor will enter MCO and MMP selections directly into the VaMMIS, according to guidelines set forth by the Department in Section 3 of this RFP. The Contractor shall be responsible for collecting, maintaining, analyzing, and disseminating enrollment and disenrollment data. The Contractor shall ensure that the ongoing managed care enrollment process for Medicaid individuals is consistent, effective, and service oriented, continually pursuing opportunities for improvement.

Enrollment options should include enrollment requests through a variety of methods including, but not limited to the HelpLine toll-free number. The Offeror's proposal must describe in detail various options it will make available for the enrollment process, including but not limited to technology, staffing and any planned innovative processes. Additionally, the Offeror's proposal must include a detailed implementation plan. The implementation plan must demonstrate the Contractor's proposed schedule to implement full operations within 90 days of contract award to successfully manage the requirements described in sections 3 and 4 of this RFP.

3.2 Populations Covered

The Contractor is responsible for the full scope of enrollment related activities for the managed care eligible Medicaid and CCC population enrolled in managed care, as described in Sections 3 and 4 of this RFP. The Offeror's technical proposal shall describe how it will distinguish each program/population; i.e. Foster Care, CCC population, for monitoring and reporting purposes. Call volume and enrollment data for both the CCC program and the MEDALLION 3.0 program from July 2011 through March 2015 as well as projections for call volume and enrollment up through June 2018 are listed in Attachment XXVI.

3.3 HelpLine Operations and Telephone Call Center Requirement

3.3.1 Office Locations

The Offeror shall enumerate the geographical locations of its firm at the national, regional, and local levels, as applicable. The Offeror shall identify all locations that will be used to support this contract and the operations handled from these locations, particularly noting any Virginia-

based locations that will be used. The Offeror should clearly identify any overseas locations that may be used to support the resultant contract or any related transactions.

3.3.2 Business Office Location

The Contractor must operate a dedicated business office based in the Richmond Virginia metropolitan area. The Offeror shall specify staff to be located in the business office; at a minimum, the Project Director and Offeror specified program operations staff shall be located in the office. The Contractor shall maintain business office hours from 8 A.M. to 5 PM EST Monday-Friday, except state holidays, and have the capacity to respond to walk-in inquiries at the Virginia business office. The Contractor shall provide an administrative telephone number that will enable DMAS staff to reach the Project Director and key staff directly without going through the Call Center staff.

3.3.3 Helpline and Telephone Call Center Location

The call center must be located in the Richmond Virginia metropolitan Area. The Contractor must also provide the capacity for the Department to monitor calls in real time remotely from DMAS offices at no cost to the Department.

3.3.4 Remote Monitoring

The Contractor must provide the capacity for the Department to monitor calls remotely in real time at no cost to the Department. The Offeror's proposal must include a description of the method that it will provide to enable the DMAS Enrollment Broker Contract Administrators to perform routine remote and on-sight monitoring of Customer Services Representative (CSR) calls under the contract. The Contractor must provide an appropriate work space for the Department's Contract Administrators (separate walled office with door, computer with internet access) as well as the necessary telephone, etc., technology for monitoring call center activities.

3.3.5 Toll Free Numbers

The Contractor shall provide and maintain a toll free telephone call center with two toll free numbers owned and controlled by DMAS (1-800-643-2273 and 1-855-889-5243) known as the Managed Care Help Line and the Commonwealth Coordinated Care Helpline respectively, during normal business hours. As it is anticipated that the majority of the inquiries and requests for the managed care program shall be received through the call center, DMAS requires a highly effective, responsive and quality-driven operation. The Contractor must supply and furnish this office at its own expense, to include telephones, fax, paper supplies, personal computers, etc.

3.3.6 Written Call Policies, Procedures and Scripting

The Contractor shall assure that calls are transitioned seamlessly and correctly in-house regardless of the phone number (if using separate phone numbers) or prompt entered by the

member. The Helpline's responsibilities will be to educate members regarding managed care and enroll members into the MCO/MMP of choice. The Contractor, with Department's approval, shall develop criteria for call handling, and produce a written manual of policies and procedures, including specific scripts and responses for staff training and operations. Contractor staff must be informed of any program changes on an on-going basis by the Department and provided specific resource/research material for each change that has been approved by the Department.

3.3.7 Call Center Hours

The HelpLine shall be staffed a minimum of 9 1/2 hours a day, 8:30 AM - 6 PM, Eastern Standard Time, Monday through Friday, except state holidays. Under special circumstances, the Department shall request the Contractor work weekend hours with at least one-week advanced notice.

3.4 Staffing Requirements

The Contractor must provide the Department with an organizational chart with its submitted proposal, on an annual basis, and as changes occur following contract award, depicting each functional unit of the organization, number and type of staff for each function identified and lines of authority governing the staff. The names of key personnel (i.e., Regional Manager, local Project Director, Call Center Manager, IT Systems Manager, Quality Assurance/Training Manager and Call Center Supervisors must be shown on the organizational chart. The minimum required staffing levels shall be as follows: 1 Regional Director, 1 local Project Director, 1 Systems Administrator, 2 Quality Assurance/Training Managers, 1 HR Manager, 1 Call Center Manager, 2 Call Center Supervisors (MEDALLION 3.0 and CCC Program), 1 Clinical Nurse/Licensed Clinical Social Worker, and a sufficient number of Customer Service Representatives (full and part time), to manage all enrollment related activities for all populations, in a timely and accurate manner as described in this RFP. The Contractor must demonstrate an active recruitment process for all vacant positions, including position descriptions and salary requirements.

Note: *If there is a loss of a critical management position such as IT Administrator or Quality Assurance/Training Manager, a Staffing Transition Plan must be provided to the Department immediately to include a contact list of current staff who are assigned additional duties, systems administration coverage assignment and designated quality assurance monitoring and reporting functions arrangements for interim period.*

The Contractor *is not required* to have dedicated staff by program, and may cross-train staff on all programs.
Under the existing Enrollment Broker Contract, staffing levels for both the MEDALLON 3.0 and CCC programs as of March 2015 are reflected in the table below:

Quantity	Staff Position
1	Project Director
1	IT Systems Administration Manager
2	QA/Training Managers

1	HR Manager
1	Business Analyst
1	Call Center Manager
2	Call Center Supervisors
2	Quality Assurance Analysts
2	Team Leads – CCC, Team Lead – Medicaid Managed Care
27	Enrollment Services Representatives

Offerors shall describe in their proposals the turn-over rate in the last 2 years at various staffing levels, including executive management, middle operations management, customer service representatives, call center management, and other key positions that would be required to fulfill the requirements outlined in this RFP.

3.4.1 Staffing Descriptions

The Contractor shall not have an employment, consulting, or any other agreement with a person or entity that has been debarred, suspended, or otherwise excluded from participating in state or federal procurement activities or federal health care programs.

1. A full-time Administrator, i.e. local Project Director, dedicated 100% to the project, tasked with overall responsibility for all aspects of performance, including the coordination and operation, of this RFP. This person shall be at the Contractor's officer level and must be approved by the Department, including upon replacement.
2. Sufficiently trained and experienced full-time staff to maintain a toll-free education and enrollment customer service phone line to be opened during regular call center hours to be responsible for explaining the program, assisting the members in choosing a MCO/MMP, educating members on how to access services, entering enrollments directly in VaMMIS system and handling member inquires/complaints.
3. An experienced IT Systems Administration Manager, tasked with coordinating required systems maintenance with Corporate entities, vendors and project staff, maintaining systems interfaces, PC based applications, the LAN, intranet and phone systems, including ACD system.
4. Quality Assurance/Training Manager trained and experienced in call center management, quality assurance activities and developing and delivering conducting training modules. Ability to complete reporting requirements.
5. A Human Resources Manager who coordinates financial responsibilities, relationships with staffing vendors, and provides the Department's monthly invoice and reporting.
6. A Call Center Manager (English and Spanish Speaking) who ensures adequate maintenance of all DMAS dedicated phone lines adhering to high quality and contract performance standards, managing front-line staff and responding to ad-hoc needs of the Department.
7. Highly trained Call Center Supervisors or Team Leads, for the CCC program and the MEDALLION 3.0 program who handle front-line operations, are able to handle supervisory complaint calls, communicate with the Department daily if needed, perform VaMMIS overrides when needed and provide ad-hoc reports for Contract Administrators.

8. Quality Assurance Analyst specifically trained to monitor enrollment activity in VaMMIS and complete internal staff audit progress reports and report any discrepancies to management.
9. A Clinical Nurse/Licensed Clinical Social Worker who has a work background that includes experience working with and effectively communicating with special needs populations such as elderly patients with early stage Dementia or Alzheimer's and/or mental illness, and intellectual disabilities.

3.4.2 Customer Service Representatives (CSRs)

The Contractor shall screen, train and supervise a sufficient number of customer service/enrollment staff to maintain on-site and HelpLine access, during normal and peak times. The Contractor shall ensure that personnel are fully trained and knowledgeable about Virginia Medicaid standards and protocols. The Contractor should select representatives who are able to best serve member populations covered under this RFP.

The Contractor must seek high quality customer service/enrollment staff with the following capabilities:

- Enthusiasm and professionalism about the role they will play in providing counseling, education and customer service to the Medicaid population and/or representatives.
- Good interpersonal and communication skills, including extensive customer service skills.
- Ability to quickly learn the accurate factual information that will be conveyed, and a readiness to use materials to research and resolve caller inquiries.
- Awareness of confidentiality and HIPAA guidelines.
- Ability to use multiple computer systems to access and input data.

In addition, the Contractor shall recruit, hire and train customer service/enrollment staff who shall, at a minimum:

- Produce a system of call content documentation, capturing all aspects of the call transaction.
- Provide a highly effective and responsive operation in handling complaints/grievances.
- Provide professional, prompt and courteous services to individuals and view quality customer service as a high priority. Greet all callers and identify them by name when answering. Treat all individuals with dignity and respect and ensure each individual's right to privacy and confidentiality.
- Promote the delivery of services in a culturally competent manner to all individuals including those with limited English proficiency and diverse cultural and ethnic backgrounds.
- Provide access to a native speaking representative (2 front-line Spanish-speaking staff required in-house) or to telephone based translation services. The Enrollment Broker shall ensure that enrollee language needs are addressed. This applies to all non-English speaking individuals and is not limited to prevalent languages.
- Establish and maintain effective working relationships and communication with the Department, MCOs, MMPs, Health Care Providers, Local Department of Social Services, Long Term Care Facilities, and Managed Care individuals.

- Effectively communicate with individuals, including those with special health care and communication needs such as hearing/speech impairments, interpreter services, etc.
- Assist individuals in selecting a MCO/MMP in an efficient, and unbiased manner; ***Representatives of the Enrollment Broker shall not recommend one health plan over another;*** but give specific information about the MCO/MMP's network of providers including physicians, hospitals, home health agencies, personal care providers, etc.
- Inform individuals of the circumstances in which individuals are excluded from the mandatory managed care participation.
- Accurately and appropriately explain the managed care eligibility guidelines in response to managed care related inquiries.
- Possess knowledge of managed care covered, non-covered and carved-out services and how to access these services through the managed care programs or other sources.
- Exercise sound judgment and act responsibly and professionally in stressful or unpleasant situations.
- Assist individuals eligible for managed care in the resolution of problems relating to the accessibility of health care delivery, including but not limited to, identifying provider issues, language barriers and special needs or disability accessibility issues.
- Inform new Medicaid individuals with children under 21 of the importance of well child care, including immunizations and services available under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program.
- Provide information on how and when to access the MCO/MMP's and the Department's Medicaid individual services or grievance/appeals departments.
- Help Medicaid individuals maintain continuity of care through existing Medicaid individual/provider relationships by assisting them with provider access issues; answering questions regarding MCO/MMP provider network participation; and explaining how specialized services should be accessed through managed care programs.
- Respond to provider questions concerning Medicaid individual assignment and refer provider eligibility questions to the appropriate MCO/MMP or fee-for-service provider helpline.
- Be alert to possible discrepancies between the MCO/MMP's approved materials and methods and anecdotal information provided by Medicaid individuals. Any discrepancies discovered should be documented and forwarded to the Department.
- Refer callers to DMAS, Managed Care, FAMIS, CCC, MCO and MMP websites for additional information when appropriate.
- Offer all callers the opportunity to participate in a customer satisfaction survey and transfer caller into an interactive voice response system to complete.

3.4.3 Licensure (or Required Registration)

The Contractor is responsible for ensuring that all persons, whether they are employees, agents, Subcontractors, or anyone acting for or on behalf of the Contractor, are legally authorized to render services under applicable state law and/or regulations. The Contractor shall ensure that personnel who are professionally licensed and/or certified keep licensure and/or certifications current and provide proof of continued licensing and/or certification to the Contractor within 1 month of licensure/certification expiration.

3.5 Staff Training

Because Call Center Performance is critical to the success of this contract, the Offeror shall describe in detail how it will train staff to perform their duties accurately and efficiently and how it will monitor performance standards.

The Contractor shall develop and maintain an extensive training program for new and experienced employees. Training modules must include all populations served in programs managed under this contract. Training must emphasize the importance of objectivity towards all health plans and individual choice. Training shall also emphasize that all callers be treated with dignity and respect, and be sensitive to the caller's need for privacy.

The training program shall:

- Provide all staff with the knowledge, skills and system capabilities they require to be effective and responsive to caller inquiries.
- Be written and comprised of three components: educational objectives, training modules, which, at a minimum, shall include a Customer Service training module for all populations, and a schedule that details each training element.
- Provide online reference tools where staff can access up-to-date resource information.
- Enable staff to understand and effectively act on the following:

    1. The mission, goals, and structure of Virginia's managed care programs.
    2. The Medicaid individual population, including eligibility guidelines for the managed care programs.
    3. Covered services under the CCC program.
    4. EPSDT program and services.
    5. Medicaid individual health care needs.
    6. Medicaid individual confidentiality.
    7. The use of the dedicated computer system and systems operations.
    8. VaMMIS training for enrollment entries.
    9. Proper procedures to document and forward complaints, grievances, and appeals
    10. A procedure for staff to respond to caller who may call in a crisis situation (i.e. may need 911 intervention).
    11. Successfully enroll Medicaid individuals timely, including in the health plan of their choice by the Managed Care cut-off date.
    12. Include effective program integrity training and education for all staff.
    13. Recognition and reporting of suspected child abuse or neglect; and abuse, neglect or exploitation of adults.

- The Offeror's proposal must describe in detail the proposed staffing plans, training plans, policies and procedures.

3.6 Call Center Performance Standards

Present Call Volume for Medicaid population: In calendar year 2014 the MEDALLION 3.0 program averaged 16,199 incoming calls per month and the CCC Program averaged 7,380 incoming calls per month. Refer to Attachment IV for more information on call volume data.

The Contractor shall be responsible for ensuring that the Call Center meets the following performance standards:

3.6.1 The Call Center telecommunication systems shall be fully accessible and functional during RFP prescribed business hours measured on a monthly basis 95% of the time.

3.6.2 90% of all incoming calls must be answered within 120 seconds or less *(an automated voice response system which places call in queue for English/Spanish may be used at initial time of call).*

3.6.3 The rate of abandoned calls shall not exceed 5% per month measured each month *(Formula: Total number of calls abandoned divided by incoming calls).*

3.6.4 All call inquiries that require a return call to the member shall be returned within one business day.

3.6.5 Only calls that meet the criteria specified by the Department should be referred to the Department, i.e. FFS billing/claims issues, complex coverage/eligibility, and urgent clinical or critical complaint issues.

3.6.6 The Contractor must develop a quality assurance process within 60 days of the contract begin date that is approved by the Department and that continually audits telephone calls for customer service skills as well as accuracy and timeliness of responses. Quality assurance validation should be at 97% measured monthly. The Contractor must provide information that documents this process report for review by the Department in the response to this RFP. Deficiencies must be addressed immediately. The Department may audit the HelpLine for monitoring and quality improvement purposes at any time, including on-site or remote monitoring.

3.6.8 The contractor shall participate in biweekly call calibration sessions with the contract monitor that will measure performance of a statistically valid sample of call recordings using an agreed upon quality scoring criteria

3.6.9 The blockage rate for the call center should be no more than 2% per month, measured each month.

The performance standards noted above must be met for all populations served. The Contractor shall also provide call center reports based on the requirements described in Section 4 of this RFP. Penalties associated with failing to meet performance standards are identified in Attachment XIX of this RFP.

Because call center performance is critical to the success of this project, the Offeror shall describe in detail how it will monitor these standards and perform corrective actions when necessary. Additionally, the Contractor shall notify the Department of any variance from the contractual requirements as outlined in this RFP and must provide a written corrective action plan addressing the deficiency (see Section 3.25.7).

The Technical Proposal shall include a copy of the Offeror's weekly, monthly and yearly performance data with an existing enrollment broker contract similar in size and complexity to the program

described in this RFP within the period immediately preceding the RFP issue date. Performance data shall include the data specified in Section 3.6 above.

3.7 Telecommunications System

The Contractor shall install, operate, monitor and support an automated call distribution system that is sufficient to handle each required program. The Offeror must provide as part of its proposal a description of the technological capabilities that it will use to meet these required capabilities.

The Contractor's telecommunication system shall have the capability to accept local and toll-free calls, make outbound calls, and meet all of the following requirements:

- Have the capacity to handle all telephone calls at all times during the hours of operation; have the upgrade ability to handle any additional call volume during peak hours. Have adequate staffing and equipment during high peak times such as open enrollment, new program implementations, expansions, etc. Any additional cost for staff, equipment, or other needs, shall be the responsibility of the Contractor.
- Effectively manage all calls received by the automated call distributor and assign incoming calls to available staff, i.e. bilingual, in an efficient manner.
- Manage outbound call volume.
- Provide detailed analysis by program of the calls received, including quantity, time it takes to answer calls initially (by ACD system), length of time it takes the caller to reach a live person, and length of call.
- Provide educational messages (i.e. announcement of new program changes or reminders) approved by the Department while callers are on hold.
- Ensure TDD/TTY capabilities.
- Refer calls to the Department's (FFS) Provider and Medicaid individual HelpLines and all participating MCO/MMPs when appropriate.
- Ensure that the installation and maintenance of its telephone system functions in a way that allows calls to be monitored by DMAS or its designee for the purposes of evaluating Contractor performance with a message which informs callers that monitoring may occur. Call monitoring by DMAS or its designee must be available at the location of the Contractor as well as remotely from DMAS or its designee's location. Remote access must be obtained through a secure communication connection such as Citrix, Virtual Private Network (VPN) or a DMAS approved secure internet connection.
- Administrative lines shall not be recorded.
- Digitally record and store 100% of incoming and outgoing calls for quality assurance purposes for a period of no less than 12 months. DMAS shall have full remote access via secure internet connection to call recordings and shall have ownership and control of these recordings
- Ensure that there is a back-up telephone system in place that shall operate in the event of line trouble or other problems so that access to the HelpLine by telephone is not disrupted.
- Ensure that telephone translation services are accessible via the toll-free number and that Medicaid individuals will be involved in three way conversation with the language line without having to make an additional call.
- Report and assess the busiest day by number of calls.
- Measure the number of calls in the queue at peak times.

- Provide detailed daily reports of abandonment rate, average wait time to abandon, and average wait time to answer after call transfer.
- Provide real-time information (queue monitoring) on call center performance, e.g., outgoing calls, calls waiting, agents logged-in, available agents (locally/overflow call center), etc. that can also be viewed remotely at the workstation computer at the DMAS office of the Contract Administrator.
- Ensure call tracking reporting by program.
- Ensure reporting of complaints and grievances by individual MCO/MMP or FFS.
- Report types of calls by program (either through the ACD system or via the Enrollment Broker's automated internal tracking system.) Refer to Attachment V for more details.
- All calls received by the overflow call center shall interface with the call tracking and recording standards and technology required in this RFP. Additionally, all contract quality and performance standards required in this contract shall apply to the overflow call center.

All data contained within the Contractor's Call Center database is the property of the Department and shall be provided to the Department upon contract termination or expiration and upon request.

The Contractor agrees to relinquish ownership of the toll-free number(s) upon contract termination or expiration, at which time the Department shall take title of these telephone numbers. All costs accrued, due, and owing on these numbers, including but not limited to, any taxes, penalties or fines shall be the sole obligation of the Contractor.

3.8 Language and Disability Requirements

The Contractor shall provide access to a native speaking representative or to telephone based translation services. Therefore, the Contractor shall ensure that Medicaid individual's language needs are addressed. This applies to all non-English speaking Medicaid individuals and is not limited to prevalent languages. The Medicaid individual cannot be charged a fee for translator or interpreter services. The Virginia Relay Service (TDD/TTY) for the deaf and hard-of-hearing must be available to Medicaid individuals and used by the Contractor when appropriate.

Printed material should be oriented to the target population, written at the 6th grade reading level, and be clearly legible with a minimum font size of 12 point, unless otherwise approved by the Department. The Contractor must provide for translation of printed materials into Spanish. The materials may also be produced and distributed in other media formats as deemed most effective by the Contractor and the Department to accomplish specific objectives within the education and enrollment functions as described in this RFP. The content and volume of all materials, whether printed or distributed via other formats must address the informational needs of those Medicaid individuals who speak languages other than English or Spanish, those with visual or hearing impairments, or those whose literacy level renders printed material less than effective.

The Contractor's informational materials must indicate the ability to provide translation services as dictated by the targeted populations. The Contractor must ensure that the special communication needs of all aged or disabled Medicaid individuals are addressed including access to a TDD/TTY, according to Commonwealth of Virginia state regulations.

3.9 Processing Enrollment Requests

The Contractor shall process 100% of enrollment changes and additions on the same day the request is received. The Contractor shall process enrollments during the five regional open enrollment periods for MEDALLION 3.0 by the VaMMIS mid-month processing date of the second month of the open enrollment period or by the last day of the month for new enrollments to avoid incorrect managed care assignments or auto-assignments that are not the choice of the Medicaid individual. The performance standard for this process will be measured monthly.

Enrollment requests received by mail from Medicaid individuals, via the Department, that cannot be processed due to incomplete information must be documented with the missing information highlighted. Where possible, the Medicaid individual shall be telephoned within 1 business so the missing information can be obtained immediately. Once the missing information is obtained, the enrollment form shall be processed within the same guidelines set above.

The Contractor must provide the enrollment staff with the current regional comparison charts and other relevant materials developed by Contractor and the Department to assist the Medicaid individual in selecting the most appropriate health plan. At a minimum, information to be considered in the decision includes: MCO/MMP which serves individual city/county, contracting hospitals, specialist network, and standard and special health care services offered by each health plan.

In processing enrollment requests, the Contractor shall:

- Establish procedures subject to Department approval, to determine when Department intervention should be sought and how it should be obtained to adequately resolve or respond to Medicaid individual or provider issues.
- Ensure representatives have received extensive customer service telephone training and Virginia Medicaid specific training to include Medicaid, EPSDT, Foster Care, etc. program instruction.
- Maintain a plan for "triaging" Medicaid individual calls, which are determined to be outside the scope of the HelpLine's expertise, to the MCO/MMP's Medicaid individual service representatives, the correct local social service agency (DSS) for Medicaid eligibility questions, the Department's Recipient or Provider HelpLines or to the Department's managed care staff.
- Capture and refer exemption and good cause requests using a format/process agreed upon by the Department and the Enrollment Broker.
- Coordinate with the appropriate Department's staff regarding Medicaid individual and provider enrollment issues and continuity of care; and,
- Identify and report to the Department Medicaid individuals with other benefit coverages such as Group Health Insurance (TPL) or change of address, etc.
- Enrollment changes and additions carried out by the contractor shall be correct and reflect the member's choice 95% of the time, measured monthly.

3.10 Policies and Procedures

The Contractor must develop policy and procedure manuals for Medicaid program for each of the Contractor functions. The policies and procedures must ensure accuracy, timeliness, and consistency of work processes and ensure against fraudulent enrollment. Policy and procedure manuals must

contain workflows for the provision of required functions, to include but not be limited to, incoming call process, outbound call process, plan changes, exclusion/exemption requests, twelve month enrollment process, and complaints, grievances, and appeals. The workflows shall include time frames for completion of function, where applicable, and must be approved by the Department. The roles, responsibilities, Medicaid individual and organizational contacts, and protocols and procedures for all Enrollment Broker Staff must be included.

The policy and procedure manuals must be provided to the Department for review and approval 60 days prior to the implementation date.

These manuals shall be used as training tools, and subsequently as references when performing enrollment activities. All staff at the call center, including the primary and any secondary sites, if applicable, shall have updated manuals to aid them in answering Medicaid individual questions and processing enrollments. The Call Center manual shall include a module on all Medicaid programs containing specific scripts for CSR staff use.

All manuals must be reviewed at least every six months for accuracy, contain up-to-date information and incorporate all revisions provided by the Department. All updates must be forwarded for the Department's review and approval before dissemination.

The Contractor shall provide the Department with both a hard copy and an electronic copy of the manuals at implementation, upon additional updates, and at least annually. Updates and changes to policies and procedures manuals shall include a change control process that documents new policies and procedures, the date the new policy and/or procedure was updated and the initials of DMAS contract monitor who approved the changed policy or procedure.

3.11 Problem Resolution Process

The Contractor shall respond to and make its best efforts to resolve non-clinical managed care related inquiries and complaints from Medicaid individuals, prospective Medicaid individuals, and people assisting Medicaid individuals or acting on behalf of Medicaid individuals, including family members, other state agencies, advocates, social services workers or providers. These inquiries and complaints may include, but are not limited to, access to health care and services, receipt of enrollment information including identification cards, transportation coordination, dissatisfaction with a provider or health plan, and non-participation of providers or hospitals in health plans. All responses and resolutions shall be HIPAA compliant, in accordance with the Department's policies and procedures, and clearly documented in the Contractor's complaint tracking system. The problem and its resolution shall be documented on a complaint log. The 6 categories of complaints for tracking purposes shall include but are not limited to: Transportation, Access to Health Services/Providers, Provider Care and Treatment, MCO/MMP Customer Service, Administrative Issues, and Reimbursement.

The Contractor has the initial responsibility for helping Medicaid individuals resolve managed care issues and complaints. Complaints forwarded to the Department for resolution that are determined to be within the Contractor's ability to resolve will be returned for immediate resolution.

The Contractor must provide information on how to access the MCO/MMP's internal grievance/appeals procedures, the State Fair Hearing process, and guide the Medicaid individual through the process, documenting problems or complaints with providers and the MCO/MMPs that have not been satisfactorily resolved, and notifying the Department and the MCO/MMP, if applicable, of the problem.

The Customer Service Representatives shall also work with the Medicaid individuals to take a proactive position in informally resolving non-clinical problems before they enter the grievance and appeals process, or provide the proper referrals. These efforts must be clearly documented on the complaint log and reported to the Department weekly and monthly. If additional follow up is required by the Department on weekly complaints, the Contractor shall clearly note in the resolution summary information that follow up is needed by the Department. The Department will forward these complaints to the appropriate MCO/MMP and upon resolution, will communicate resolution back to the MC HelpLine to be entered into the Contractor's database for closure.

3.12 State Fair Hearing Process

Medicaid members have the right to appeal adverse actions to the Department as described in 42 CFR §431, Subpart E, and the Virginia Administrative Code at 12VAC30-110-10 through 12VAC30-110-370. The Contractor must educate members regarding their right to appeal adverse actions to the MCO or directly to the Department, provide information regarding the allowable timeframes to file an appeal, and provide the Department's address to be used for filing an appeal.

For individuals who do not understand English, a translation of appeal rights that can be understood by the individual must be provided. Appeals must be requested in writing and postmarked within 30 days of receipt of the notice of adverse action. The client or his authorized representative may write a letter or complete an Appeal Request Form. Forms are available on the internet at www.dmas.virginia.gov, or by calling (804) 371-8488.

If requested by the Contractor, the DMAS Appeals Division will conduct training during the implementation of the contract. Such training shall be conducted on a date and time to be set by the DMAS Appeals Division. Training shall be conducted at DMAS headquarters in Richmond, Virginia.

3.13 Call Tracking System

The Contractor shall be responsible for establishing a database for logging calls from Medicaid individuals by Medicaid individual ID number and Medicare ID# for CCC enrollees associated to FIPS locality/region. The system must include, at a minimum, the Medicaid individual's name, Medicaid identification number, type of call, length of call, telephone number if available, name of the MCO/MMP and pertinent staff, when appropriate, name of the Medicaid individual's PCP, and other providers, information concerning the nature of the call (capture all important aspects of the call transaction), a record of the date of receipt of the call, the resolution and/or if additional follow-up required and any other information the Department specifies. The Contractor shall report individual call activity data to the Department upon request. Information contained in the database shall be the property of the Department.

As part of the call tracking system, the Contractor shall report separately on complaints (weekly, monthly, and annually) by program (MEDALLION 3.0 and the CCC program). Complaints requiring the immediate attention of the Department must be reported daily, following the occurrence, via phone or secure email notification.

3.14 Integrated Voice Response System

The contractor shall develop an integrated voice response system (IVR) for the call center that will prompt callers to enter their Medicaid identification number or social security number prior to the call being be placed with a CSR. The CSR's call documentation software shall be auto-populated with relevant information from prior calls as well as demographic, member enrollment and eligibility information from the VaMMIS, as determined by the Department. The IVR shall also have the capability to allow callers to determine what plan they are currently enrolled with and/or what plan they will be enrolled within the next 30 to 60 days by keying in their Medicaid ID# or Social Security Number, if applicable.

3.15 Enrollee Education

Educational services shall be made available to the populations covered under this RFP. Education shall be provided to newly eligible Medicaid individuals as well as to Medicaid individuals who are currently or have been previously enrolled. This task requires a series of activities, the end purpose of which is the enrollment of an informed Medicaid population into managed care programs. After completing a preliminary HIPAA verification, the Contractor shall verbally provide information to parents, guardians or other representatives who contact the Help Line, to include but not limited to:

- The importance of receiving primary and preventive care, including immunizing children, how to get information about the type and frequency of required immunizations, and well child visits;
- Primary Care Provider (PCP) and specialty care providers, including long-term care providers, in the MEDALLION 3.0 Program or CCC Program as appropriate;
- Program changes such as the twelve-month enrollment, expansions, open enrollment processes, etc. The Department shall provide in-service training to the Contractor regarding program changes. The Contractor shall ensure the dissemination of accurate information about the changes to all internal staff.
- EPSDT (Early and Periodic Screening Diagnosis and Treatment) services available for eligible MEDALLION 3.0 individuals under age 21, as described in this RFP.
- Information on dental screening and referrals for MEDALLION 3.0 enrollees to the Medicaid dental contractor Help Line, as appropriate.
- Care coordination assistance available through the Medicaid individual's MCO/MMP for Medicaid participants.
- Behavioral Health Administrator contact information.

3.16 Virginia Medicaid Program Specific Knowledge

The Contractor must develop expertise in managed care philosophy in general and the Virginia Medicaid delivery systems in particular. The Contractor shall be knowledgeable of the organization and goals of the Department as they relate to managed care and Medicaid individual enrollment. The

Contractor shall meet with the Department's Integrated Care and Health Care Services Divisions to gain an understanding of the managed care programs, including the similarities and differences between services and populations. Information on Medicaid is available on the Department's website at the following links: http://www.dmas.virginia.gov/Content_pgs/mc-home.aspx

The Contractor must meet with each MCO/MMP to obtain detailed information about the MCO/MMP's Medicaid individual operations for Medicaid. These meetings must take place within 30 business days after the implementation date and annually thereafter. The Contractor must identify a liaison at each MCO/MMP to foster ongoing communication between the Contractor and each MCO/MMP. The Contractor shall notify the Department of any health plan changes by CCC members on a monthly basis.

The Contractor must become familiar with each MCO/MMP's provider network. Knowledge of the location of practitioners, hospitals, clinics, etc. will be necessary to assist Medicaid individuals in selecting an MCO/MMP.

The Contractor must be alert to possible discrepancies between the MCO/MMP's approved materials and actual practices as they are reported by Medicaid individuals. Any discrepancies discovered should be documented and forwarded immediately to the Department for review.

3.17 Virginia Medicaid Management Information System (VaMMIS)

In response to this RFP, the Offeror must demonstrate the ability to interface with the VaMMIS system and through the DMAS fiscal agent to provide data and other information to the Department. The Contractor interface with VaMMIS will include Medicaid participant enrollment information in standard EDI format. The Contractor shall have adequate personnel and resources in place to meet all standards and procedures regarding receipt, processing and transmission of program information as described in this RFP. All Contractor staff shall have access to equipment, software and training necessary to accomplish their stated duties in a timely, accurate, and efficient manner. The Contractor shall supply all hardware, software, communication and other equipment necessary to meet the requirements of this RFP. The Contractor shall allow sufficient time for installation, configuration, and testing of the data line and associated equipment prior to production.

3.18 VaMMIS Connectivity

The Contractor shall be responsible for providing connectivity to the VaMMIS. Any expenses, including equipment, services, etc., incurred in establishing and maintaining connectivity between the Contractor and the Fiscal Agent hosted VaMMIS system will be the responsibility of the Contractor.

It is the responsibility of the Contractor to ensure that bandwidth is sufficient to meet the performance requirements of this RFP. The Contractor will be granted access to VaMMIS through the web portal https://www.virginiamedicaid.dmas.virginia.gov/wps/portal with a secure sign on controlled and managed by DMAS. This will enable the Contractor to view eligibility and other pertinent MMIS data as deemed necessary by DMAS. All employees supporting this contract must have access to the Internet. The Contractor shall ensure that staff attend VaMMIS training provided by the Department.

3.19 Secure Email

The Contractor shall provide secure email services between DMAS and the Contractor and any other entity where PHI is communicated. No direct connection of VPNs to DMAS shall be used for this purpose nor will DMAS use individual email certificates for its staff. DMAS will provide no special application server(s) for this purpose.

It is recommended that the routing of emails between DMAS and the Contractor shall support Secure SMTP over Transport Layer Security (TLS) RFC 3207 over the Internet. The solution must include a method for secured industry standard email using strong encryption keys (greater than 128 bit) between DMAS and the Contractor throughout the contract term. TLS email encryption shall be maintained through the mail gateway. Bidirectional TLS email encryption must be tested and documented between DMAS and the Contractor's SMTP server. DMAS additionally has implemented functionality that allows for point-to-point TLS email encryption.

All expenses incurred in establishing a secure connectivity between the Contractor and DMAS, any software licenses required, and any training necessary shall be the responsibility of the Contractor.

3.20 Medicaid individual Database

The Contractor shall create and maintain a Medicaid individual database. The database must include documentation regarding all inbound or outbound calls, enrollments submitted by mail, MCO/MMP assignments, transfers, disenrollments, and exclusions by Department determined reason codes. The Department will provide member data on a daily basis, which the Contractor will use to maintain and update their Medicaid individual database. The data shall be provided in and conform to current EDI standards.

The Contractor's system shall also create a Medicaid individual phone number list to include information by MCO/MMP name, Medicaid individual ID and phone number changes/updates. The Contractor shall post this phone number list weekly on an FTP server for each MCO/MMP outbound folder and send monthly to the Department. All data contained within the Contractor's Medicaid individual database is the property of the Department and shall be provided to the Department upon contract termination.

Reporting from the Contractor Medicaid individual database is described in Section 4 of this RFP.

3.21 Managed Care Organization (MCO/MMP) Provider File

The Contractor shall receive and load a full monthly provider file, to include active and deleted providers and all provider types and specialties from each of the Department's contracted MCO/MMPs. The Contractor shall receive and download separate provider files from each MCO/MMP via FTP secure server. Further, the Contractor shall utilize the correct MCO/MMP's provider file when answering questions from Medicaid participants. MCO/MMP provider files shall include, but not be limited to, primary care providers, specialists, ancillary providers, hospitals, home health agencies, durable medical equipment, and pharmacies. The Contractor must work with the Department and the MCO/MMP regarding an acceptable format to accept consistent values for

provider specialty designations for the provider files. The correct MCO/MMP provider file information shall be available to the customer service representatives to answer questions from Medicaid individuals regarding where providers are located and which health plan they participate with. Each new monthly file will replace the previous monthly file.

3.22 MCO/MMP and Provider Network Data Base and Provider Network Verification System

The Contractor shall create a comprehensive provider network database that incorporates the MCO/MMP provider file information described above which includes, but is not limited to:

a. Provider name
b. Provider class types (e.g., physician, general hospital, home health, pharmacy, etc.)
c. Provider specialty (e.g., OB-GYN, pediatrics, cardiologist, etc.)
d. NPI/API number
e. Street address (physical location)
f. City/town as it appears on the mailing address (physical location)
g. Zip codes
h. Telephone number

The specific fields and formats for this file are documented in the Managed Care Technical Manual located at http://www.dmas.virginia.gov/Content_atchs/mc/MCTM%202%203.pdf. Additionally, the Contractor will develop an edit to prevent health plan disenrollment without simultaneous enrollment into another health plan, and special requirements or services of the PCP (hospital and specialist referrals, languages, populations served, etc.). The Contractor must acquire monthly enrollment updates or more frequently if required (i.e., program changes, expansion periods, etc.) of the provider file from each MCO/MMP. The Contractor must work with the Department and the MCO/MMP to assure all data are provided in accordance with the provider network database requirements. The Contractor provider network file shall allow for the flexibility to accommodate full replacement data and additional provider class and specialty types at no additional cost to the Department. This file should allow for removing deleted providers. This file must be provided upon request to the Department.

3.23 Virginia Managed Care and CCC Websites

The Contractor shall maintain and update the Virginia managed care websites, which are owned and controlled by DMAS (www.virginiamanagedcare.com and www.virginiaccc.com) on a shared server and compliant with the Virginia Information Technology Accessibility (VITA) Standards http://www.vita.virginia.gov/security/. These websites shall allow Medicaid individuals to click on a link to send question/comments via email; the helpline staff will check designated email daily and respond via email within one business day.

The Contractor shall ensure that the website is also available in Spanish translation for each page of the website. Routine updates shall be made by the Contractor upon request by the Department at no cost; i.e. updates to the "What's New" Section and/or announcements such as new MCO/MMP or name change to MCO/MMP and especially at critical time periods prior to Open Enrollment dates.

The Contractor shall also ensure that the website technology includes web trending software that can be accessed remotely to track the utilization of the site; i.e. total visits, total page views, top page, etc., with monthly comparison reports to the Department. The Contractor shall set up a test web site prior to implementation for review and approval through a DMAS approved change management process. Once changes are fully tested and approved by DMAS, they are to be moved to production. The Contractor will provide remote access to web trending software and the test web site from DMAS. The Contractor agrees to relinquish ownership of the website upon contract termination, at which time the Department shall take title to this web address and its contents. Web security certificates shall be current as required by VITA and DMAS for both the test and production web sites.

Features of the websites shall include, but may not be limited to:

- Information on how to enroll in MCO/MMP (Medicaid)
- Interactive link for Medicaid individuals to email questions/comments on line
- List of MCO/MMPs, phone numbers and website links for each health plan
- Additional information for pertinent contacts such as the Dental Vendor or the BHSA
- Open enrollment dates and comparison charts for cities/counties in Virginia
- What's New section for upcoming events and special announcements
- Frequently asked questions and answers
- Materials (MCO/MMP brochures/comparison charts) – with ability to print
- EPSDT related web links, including the link to the Department's Staying Healthy web page at http://www.coverva.org/main_staying_healthy.cfm Comprehensive provider network information for each participating MCO/MMP plan

In addition to the features described above, the contractor shall develop and implement a secure internet web site capability integrated in the MEDALLION 3.0 and CCC web sites that includes the capability for members to make new plan enrollments or changes to existing plan enrollments or to opt-out of the CCC program. This interactive web site capability shall be HIPAA compliant and compliant with all DMAS and VITA security rules, regulations and policy. Interactive features shall also include the ability for members to determine provider availability by plan using their physical address or zip code for provider class types as determined by the department. The contractor shall develop a process that allows plans to upload provider data on a weekly basis to update the MEDALLION 3.0 and CCC web site's provider data. The web site shall also have the capability for members to complete the Health Status Assessment (HSA) prior to finalizing enrollment. The HSA data shall be organized by plan and uploaded weekly to the MCOs via a secure FTP for the MCOs and DMAS.

3.24 Relationship with MCO/MMPs and Other Agencies

The Contractor must work cooperatively with staff at central and local DSS, Virginia Department of Health (VDH), Behavioral Health and Developmental Services, Community Services Boards, DMAS contracted MCO/MMPs, long term care providers and other community organizations. The Contractor shall provide education about the enrollment process, managed care, facilitate problem resolution and maintain open communication as calls are received through the HelpLine, to enhance enrollment activities. This will include establishing referral mechanisms to link Medicaid individuals with providers, other programs, agencies, etc. The Contractor will determine if there appears to be a

problem with DSS, MCO/MMP, etc. by increase in phone calls from certain groups and notify DMAS Contract Administrator so communication can be given to appropriate area to resolve identified issues.

3.25 Subcontractors

3.25.1 Legal Responsibility

The Contractor shall be responsible for the administration and management of all aspects of this RFP. If the Contractor elects to utilize a Subcontractor, the Contractor shall ensure that the Subcontractor shall not enter into any subsequent agreement or Subcontract for any work without prior approval of the Contractor. No Subcontract, provider agreement, or other delegation of responsibility shall terminate or reduce the legal responsibility of the Contractor to the Department to ensure that all activities under this RFP are carried out.

In accordance with requirements described in 42 CFR § 455 Subpart B, and the State Medicaid Director Letter SMDL #08-003 (available at http://www.cms.gov/smdl/downloads/SMD061208.pdf), the Contractor shall comply with all of the following federal requirements. Failure to comply with accuracy, timeliness, and in accordance with federal and contract standards may result in refusal to execute this contract, termination of this contract, and/or sanction by the Department.

3.25.2 Contractor Owner, Director, Officer(s) and/or Managing Employees

a. The Contractor and or its Subcontractors shall not knowingly have a relationship of the type described in paragraph (b) of this section with:

1. An individual or entity who is debarred, suspended, or otherwise excluded from participating in federal health care programs, as listed on the Federal List of Excluded Individuals/ Entities (LEIE) database at: https://oig.hhs.gov/exclusions/exclusions_list.asp or excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.

2. An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described in paragraph (a)(1) of this section.

b. The relationships described in this paragraph are as follows:

1. A director, officer, or partner of the Contractor
2. A person with beneficial ownership of five percent or more of the Contractor's equity.
3. A person with an employment, consulting or other arrangement with the Contractor for the provision of items and services that are significant and material to the Contractor's obligations under this contract with the Department.

c. Consistent with federal disclosure requirements described in 42 CFR § 455.100 through 42 CFR § 455.106, the Contractor and its Subcontractor(s) shall disclose the required ownership and control, relationship, financial interest information; any changes to ownership and control, relationship, and financial interest, and information on criminal conviction regarding the Contractor's owner(s) and managing employee(s). The Contractor shall provide the required information using the *Disclosure of Ownership and Control Interest Statement* (CMS 1513) annually at the time of contract signing.

d. The Contractor and its Subcontractor(s) shall perform, at a minimum, a Monthly comparison of its owners and managing employees against the LEIE database to ensure compliance with these federal regulations. The LEIE database is available at https://oig.hhs.gov/exclusions/exclusions_list.asp

e. The Contractor shall report to the Department within 5 Business Days of discovery of any Contractor or Subcontractor owners or managing employees identified on the LEIE database and the action taken by the Contractor.

f. Failure to disclose the required information accurately, timely, and in accordance with federal and contract standards may result in refusal to execute this contract, termination of this contract, and/or sanction by the Department.

3.25.3 Contractor and Subcontractor Service

a. In accordance with Sections 1902(a)(39) and (41), 1128, and 1128A of the Social Security Act; 42 CFR, Part 1002; 42 CFR, §438.610; and 12 VAC 30-10-690 of the Virginia Administrative Code and other applicable federal and state statutes and regulations, the Contractor (including Subcontractors and providers of Subcontractors) shall neither participate with nor enter into any provider agreement with any individual or entity that has been excluded from participation in federal health care programs or who have a relationship with excluded provider of the type described in paragraph 1(b) above. Additionally, the Contractor and its Subcontractor is further prohibited from contracting with providers who have been terminated from the Medicaid or FAMIS programs by DMAS for Fraud and abuse. Additional guidance may be found in the Department's 4/7/09 Medicaid Memo titled, "Excluded Individuals/Entities from State/Federal Healthcare Programs", which can be located at: https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/MedicaidMemostoProviders

b. The Contractor shall inform Subcontractors about federal requirements regarding providers and entities excluded from participation in federal health care programs (including Medicare, Medicaid and CHIP programs). In addition, the Contractor should inform Subcontractors about the Federal Health and Human Services – Office of Inspector General (HHS-OIG) online exclusions database, available at http://exclusions.oig.hhs.gov/, where providers/Subcontractors can screen managing employees, contractors, etc., against the HHS-OIG website on a Monthly basis to determine whether any of them have been excluded from participating in federal health care programs. Providers and subcontractors should also be advised to immediately report to the Contractor any exclusion information

discovered. The Contractor and its Subcontractor(s) shall perform, at a minimum, a Monthly comparison of its providers against the LEIE database to ensure that their contracted health care professionals have not been included on the LEIE database, available at https://oig.hhs.gov/exclusions/exclusions_list.asp. Federal health care programs include Medicare, Medicaid, and all other plans and programs that provide health benefits funded directly or indirectly by the United States.

c. The Contractor shall report to the Department within 5 business days of discovery of any Subcontractors that have been identified on the LEIE database and the action taken by the Contractor.

d. Failure to disclose the required information accurately, timely, and in accordance with federal and contract standards may result in sanction by the Department in accordance with this subsection of the contract.

3.25.4 Prior Approval of Subcontracting

No portion of the work shall be subcontracted without the prior written consent of the Department. In the event that the Contractor desires to subcontract some part of the work specified herein, the Contractor shall furnish the Department with the names, qualifications and experience of the proposed Subcontractors. The Contractor shall, however, remain fully liable and responsible for the work to be done by its Subcontractor(s) and shall assure compliance with all requirements of the contract. The Department shall have the option to review and approve all written agreements between the Contractor and its Subcontractors prior to execution.

Once a Subcontract has been executed by the participating parties, a copy of the fully executed Subcontract shall be sent to the Department within 30 days of execution.

3.25.5 Notice of Subcontractor Termination

When a subcontract that relates to the provision of this RFP's scope of services is being terminated between the Contractor and a subcontractor, the Contractor shall give at least 30 days prior written notice of the termination to the Department. Such notice shall include, at a minimum, the Contractor's intent to change to a new subcontractor for the provision of said services, an effective date for termination and/or change, as well as any other pertinent information that may be needed. In addition to prior written notice, the Contractor shall also provide the Department with a transition plan, when requested, which shall include, at a minimum, information regarding how continuity of the project shall be maintained. The Contractor's transition plan shall also include provisions to notify impacted or potentially impacted providers of the change. The Department reserves the right to require this notice requirement and procedures for other subcontracts if determined necessary upon review of the subcontract for approval.

3.25.6 Performance Reviews

The Contractor shall cooperate with all performance reviews conducted by the Department or its designated agent, including providing copies of all records and documentation arising out of Contractor's performance obligations under the Contract. Upon reasonable notice, the Department may conduct a performance review and audit of the Contractor to determine compliance with the contract requirements. The Department will provide the results of performance reviews to the Contractor.

3.25.7 Contractor Corrective Actions

At any time a deficiency in the Contractor's performance is identified, the Department may request a corrective action plan. The Contractor shall develop corrective action plans and submit them to the Department, for approval, within the format and timelines prescribed by the Department.

The Contractor shall immediately notify the Department of any automated systems processes, modifications, or downtime adversely affecting internal or external systems access or functionality impacting the timeliness and accuracy of Enrollment Broker services. The Contractor shall develop, implement, and submit a corrective action plan to the Department, within 24 hours, outlining the Contractor's approach to resolving the issues including systems testing, if applicable.

3.25.8 Quality Assurance Plan

The Contractor shall have an internal Quality Assurance (QA) plan and system in place, with documented policies and procedures and internal controls, to perform quarterly operations reviews of all key deliverables. The QA plan shall, minimally, include quarterly sampling of key operation areas; outcome measurement tools; and performance analysis as compared to performance standards identified in this RFP. The QA plan shall be submitted annually to the Department for approval.

The Contractor shall provide the Department with a Quarterly QA report of sampling activities and findings that includes trend data and identifies operational area strengths and areas needing improvement including actions taken. QA reports shall be forwarded to the Department in accordance with the Required Reports provided in Section 4 of this RFP.

The Department may attend Contractor QA meetings at the Department's option.

The Technical Proposal shall include a copy of a Quality Assurance Plan and results for a contract of similar scope and size to this RFP for the quarter or period immediately preceding the RFP issue date.

3.26 Meetings

The Contractor shall participate with the Department, the MCO/MMPs, Quality Assurance Committees, or any other groups, as necessary, to meet its obligations under the Enrollment Broker Contract or as necessary when requested to do so by the Department. Required meetings include the

quarterly MCO Workgroup Meeting located at DMAS with representatives from all MCOs. The Contractor's key personnel shall meet with a Department Representative (Contract Administrator) bi-monthly and maintain meeting minutes to be distributed to the Department in a timely manner.

3.27 Program Implementations, Expansions and Changes

The Contractor shall be responsible for providing enrollment functions as required in this RFP and in the Offeror's proposal during any 1) new program implementation, 2) new MCO participation in a Medicaid region, 3) expansion of other Medicaid individual groups into Medicaid managed care program such as Home and Community Based Care Waiver programs, and 4) contract termination of an MCO plan or plans. Contract standards and quality of services shall be maintained during these occurrences.

DMAS reserves the right to negotiate payment to the Contractor as a result of any increase or decrease in population due to federal or State regulatory changes, or federally approved Medicaid waivers for Virginia, such as other managed care/care coordination initiatives described in Attachment XXV. DMAS also reserves the right to negotiate payment to the Contractor as a result of any change in the enrollment processes, including but not limited, to the inclusion of additional populations into managed care program(s). Reference Section 6.5 Payment Modifications.

3.27.1 Optional Services – Future Managed Care Initiatives

The Department is interested in the Offeror's capabilities and expertise in providing services to the populations described in this section. Services may be implemented at the Department's discretion during the period of the contract resulting from this RFP. The Offeror's technical proposal must describe the Offeror's abilities, experience, and process for serving these optional populations at a reasonable cost to the Commonwealth.

The Offeror's Cost Proposal for services to these optional populations shall be submitted, separate from the technical proposal, in Attachment III Cost Proposal. Optional Services and Costs are for information purposes only and will not be included in scoring of the proposals or evaluation process.

Future Managed Care Initiatives

In following with the 2015 Virginia Acts of Assembly, (Item 301.TTT), DMAS may transition additional populations currently served through the Medicaid fee-for-service (FFS) program into managed care delivery models. Some of these initiatives may occur during the effective dates of the Enrollment Broker Contract that results from this RFP. The Enrollment Broker Contractor shall expand its operations within 90 days of notice from the Department to meet the Department's program requirements for these initiatives.

The populations that the Department may transition from FFS to managed care include: (1) dual eligibles that choose not to participate in the CCC program; (2) dual eligibles that are not eligible to participate in the CCC program; and, (3) non-dual eligibles that use long-term services and supports (LTSS). The responsibilities required of the Enrollment Broker Contractor for these new populations would be similar in scope to other enrollment

responsibilities described in this RFP. DMAS will provide additional information regarding volume and participation, start-up and implementation periods, and any additional services required from the Enrollment Broker for these groups as this information is made available. The information below provides details available at this time for two of these planned initiatives. As the initiatives described below are in the early development phase, the information and the related requirements provided for these two initiatives are subject to change.

CCC Eligible Individuals Who Choose Not To Participate in CCC

As reflected in the table below, as of May 2015, approximately 65,500 individuals were eligible to participate in the CCC program. Approximately 30,000 of these individuals were CCC enrolled, just over 27,000 have opted-out, and approximately 8,300 CCC eligible individuals reside in an area where only one MMP participates. The Department may implement a mandatory Medicaid managed care program beginning in of the summer of 2016 to *require* participation of CCC eligible individuals, who choose not to participate in CCC, for their Medicaid coverage. (CMS rules do not allow States to mandate managed care participation for Medicare coverage.) CCC eligible individuals will continue to have the opportunity to participate in the full CCC program that integrates Medicare and Medicaid coverage. However, those individuals who elect not to participate in the fully integrated Medicare/Medicaid CCC model will be mandatorily enrolled into a managed care plan for their Medicaid coverage. (Federal rules require that individuals have a choice of at least two health plans for mandatory managed care; therefore; enrollment will not be mandatory in areas where only one health plan participates.)

CCC Member Participation By Region - May 2015				
CCC Region	**Active Opt-ins**	**Passive Opt-ins**	**Opt-outs**	**One MMP Areas**
Central Virginia	2,072	7,519	9,839	10
Northern Virginia	298	3,983	2,112	6,245
Roanoke	669	4,507	4,154	1,747
Tidewater	1,764	6,509	8,428	6
Western/Charlottesville	471	2,358	2,502	356
Total Members	**5,274**	**24,876**	**27,035**	**8,364**

The mandatory managed care program for individuals that choose not to participate in CCC may use the current CCC plans (Humana, Virginia Premier, and Anthem Health-Keepers). In addition, the same eligibility criteria will apply as will the same Medicaid covered services. Federal managed care disenrollment rules (at 42 CFR §438.56) will apply to the mandatory program, so these individuals will be permitted to change from one CCC MMP to another during the first 90 days of initial enrollment and at least annually without cause. Under the mandatory program, individuals will be permitted to request changes at any time outside of open enrollment with cause in accordance with 42 CFR §438.56(d). The open enrollment timeframe for the mandatory program may occur between October and November for a

December 1 effective date, to coincide with the Medicare's open enrollment time frame. The Contractor shall be responsible for managing the full scope of enrollment, deliverables and contractual responsibilities of all mandatory participants within the guidelines described in this RFP, DMAS guidelines, and Federal standards for enrollment of mandatory managed care populations per 42 CFR Part 438.

Managed Long-Term Services and Supports (MLTSS)

The Department is exploring the option to move dual eligibles with full Medicaid coverage, that are not eligible to participate in CCC, and non-dual individuals who use long-term care nursing facility, and home and community based waiver services, into a new mandatory managed long-term services and supports program (MTSS). As reflected in the table below, as of March 1, 2015, the anticipated volume for a program of this type is approximately 50,000 dual eligibles (where approximately 50% of these use LTSS) and approximately 20,000 non-duals with LTSS needs. If the department chooses to move forward with the MLTSS program, participating health plans will be selected through a competitive procurement process. The timeline for any MLTSS program launch is expected to begin by mid-year 2017 where the MLTSS program may be implemented in one or more phases. These phases could be regionally based and/or could be handled differently by population at DMAS' discretion. MLTSS would be unique from CCC, mandatory managed care for CCC opt-outs, and Medallion 3.0. Given that, the Department may require that the Contractor establish a separate toll-free telephone number, web-site, comparison charts, and member materials that address the unique needs of the MLTSS population. The Contractor shall be responsible for managing the full scope of enrollment, deliverables and contractual responsibilities for MLTSS within DMAS guidelines and Federal standards for enrollment of mandatory managed care programs per 42 CFR Part 438. Enrollment broker responsibilities for MLTSS participants would also include managing open enrollment, the ninety day plan trial period, and good-cause and exemption requests, per DMAS guidelines and Federal requirements described in 42CFR, Part 438. In adhering to the previously mentioned timeframe, if the Department were to move forward with MLTSS, open enrollment for the program may occur on an annual basis between October and November for a December 1 effective date, to coincide with Medicare's open enrollment time frame.

MLTSS Eligibles As of March 2015	
Population	**Approximate Volume**
Duals without LTSS	25,000
Duals with LTSS	23,000
Non-Duals with LTSS	22,000
Total MLTSS	70,000

Separate Cost Proposal for CCC Mandatory and MLTSS Programs

The Offeror shall provide a separate cost proposal for each of the two optional populations described above *(separate cost proposal for each initiative)*. The cost proposal for these programs is required in addition to other programs described in this RFP. DMAS will provide additional information regarding volume and participation, start-up and implementation

periods, DMAS guidelines, and any additional services required from the Enrollment Broker for these programs as this information is made available. The Offeror's cost proposal for these optional population groups will serve as a basis for payment negotiations that will occur as these new managed care initiatives are implemented, consistent with requirements described in this RFP and RFP addenda. The Department maintains the right to revise the requirements for these two optional populations and to determine whether to include either of the optional populations described above under the contract resulting from this RFP or under a separate contractual agreement as the Department deems appropriate.

3.28 Fraud and Abuse

3.28.1 Prevention/Detection of Fraud and Abuse

The Contractor shall have internal controls and policies and procedures in place that are designed to prevent, detect, and report known or suspected instances of fraud and abuse. Such policies and procedures must be in accordance with federal regulations described in 42 CFR Parts 455 and 456. The Contractor shall have adequate staffing and resources to investigate unusual incidents and develop and implement corrective action plans to assist the Contractor in preventing and detecting potential instances of fraud and abuse.

3.28.2 Fraud and Abuse Compliance Plan

The Contractor shall have a written fraud and abuse Compliance Plan. The Contractor's specific internal controls and policies and procedures shall be described in a comprehensive written plan and be maintained on file with the Contractor for review and approval by the Department and as an annual contract submission. The Plan must define how the Contractor shall identify and report suspected fraud and abuse by Medicaid Individuals, network providers, Subcontractors, and the Contractor. The Plan must be submitted annually and discuss the monitoring tools and controls used to protect against theft, embezzlement, fraudulent marketing practices, or other types of fraud and program abuse. The Plan must additionally describe the type and frequency of training provided to prepare staff to detect fraud. All fraudulent activities or other program abuses shall be handled subject to the laws and regulations of the Commonwealth of Virginia and/or federal law and regulation.

The Department shall provide notice of approval, denial, or modification to the Contractor within 30 calendar days of annual submission. The Contractor shall make any requested updates or modifications available for review, as requested by the Department, within 30 calendar days of a request. At a minimum the written plan shall:

1. Ensure that all officers, directors, managers, and employees know and understand the provisions of the Contractor's Fraud and Abuse Compliance Plan.
2. Contain procedures designed to prevent and detect potential or suspected abuse and fraud in the administration and delivery of services under this contract.
3. Include a description of the specific controls in place for prevention and detection of potential or suspected abuse and fraud, such as:

    a. Claims edits;

b. Post payment and prepayment of claims;
c. Service authorization;
d. Utilization management;
e. Relevant subcontractor and provider agreement provisions;
f. Written provider and Medicaid Individual materials regarding fraud and abuse prevention, detection, and reporting; and
g. Reporting protocols

4. Contain provisions for the confidential reporting by Medicaid Individuals, network providers, and Subcontractors of plan violations to the designated person as described in item b. below.
5. Contain provisions for the investigation and follow-up of any compliance plan reports.
6. Ensure that the identities of individuals reporting violations of the plan are protected.
7. Contain specific and detailed internal procedures for officers, directors, managers, and employees for detecting, reporting, and investigating fraud and abuse compliance plan violations.
8. Require any confirmed or suspected fraud and abuse under state or federal law by a provider, Medicaid Individual, their Employees, or Contractor employee to be reported to the Department.
9. Ensure that no individual who reports plan violations or suspected fraud and abuse is subjected to retaliation.

a. The Contractor shall designate to the Department an officer or director in its organization who has responsibility and authority for carrying out the provisions of the Fraud and Abuse Compliance Plan.

b. The Contractor shall notify the Department of all incidents of potential or actual fraud and abuse within 2 Business Days of receiving an allegation; initiation of any investigative action by the Contractor; or within 2 business days of Contractor notification that another entity is conducting such an investigation of the Contractor, its network providers, or Medicaid Individuals. All reports shall be sent to the Department in writing and include a detailed account of the incident including names, dates, places, and suspected fraudulent activities. In addition, the Contractor shall provide a summary report to the Department of all incidents of potential or actual fraudulent activity and results on a monthly basis.

c. The Contractor shall cooperate with all fraud and abuse investigation efforts by the Department and other state and federal entities.

d. All cases where fraud is suspected or detected shall be referred to the Department prior to the initiation of any actions or recoupment efforts. The Contractor shall provide support to the Medicaid Fraud Control Unit on matters relating to specific cases involving detected or suspected fraud.

e. The Contractor shall ensure compliance with federal rules and regulations for prohibited affiliations with individuals and entities debarred by federal agencies per 42 CFR Part 1002 and 42 CFR Part 455 Subpart B.

3.29 Readiness Review

The Department will conduct an on-site review to assess the readiness of the Contractor to effectively administer and provide the services defined in this RFP and subsequent contract. Upon approval of the Contractor's operational readiness and a determined start date, the Department Shall make payments as described in Sections 5 and 6.

No later than 60 calendar days prior to the implementation start date, the Contractor Shall demonstrate, to the Department's satisfaction, that Contractor is fully capable of performing all duties under this contract, including demonstration of the following:

a. Contractor's integrated information technology systems and services (enrollment, invoice processing, and Call Center) are adequate to ensure that there will be minimal disruptions in service;
b. Contractor has hired and thoroughly trained its staff in accordance with the requirements outlined in this RFP;
c. Contractor has trained its staff to handle telephone requests and inquiries and has provided the Department with copies of training materials and described the methods used for training and education;
d. Contractor has demonstrated the ability to accurately submit and accept, to the Department's satisfaction, all required documentation with respect to payments from the Department to the Contractor as described in this RFP;
e. Contractor's quality management/quality improvement and other pertinent components are in place in accordance with the requirements described in this RFP;
f. Contractor has successfully tested all EDI interfaces with the Department prior to implementation;
g. Contractor's telephone system is fully operational and staff training has been completed for a readiness review 15 calendar days prior to the effective date of implementation; and
h. Contractor has submitted an Implementation Plan demonstrating compliance with the terms of the RFP.

The Operational Readiness review may include, but shall not be limited to: a walk-through of the Contractor's operations; system demonstrations and testing, including connectivity and web site testing; interviews with Contractor staff; sampling of call records; live call monitoring and initiation of phone calls; correspondence review; and fraud and incident management review.

Any changes required to the Contractor's processes as identified through readiness review activities shall be made by the Contractor prior to implementation. Costs associated with these changes shall be borne by the Contractor. The Contractor's inability to demonstrate, to the Department's satisfaction and as provided in this section, that Contractor is fully capable of performing all duties under this contract no later than 12/1/2015, shall be grounds for the immediate termination of the contract by the Department pursuant to Section 10, Special Terms and Conditions, of this RFP.

3.30 Transition Activities between Incumbent Contractor and Successor Contractor

Within 10 calendar days from the award of contract, the Contractor shall schedule and attend a meeting (entrance conference) at DMAS to discuss all pertinent items relative to the contract. The Contractor shall work closely with DMAS to define project management, status reporting standards, and communication protocols to ensure an orderly transition between Contractors and prevent interruptions or gaps in services.

a. Transition activities and data exchange shall include, but not be limited to: a turnover schedule; operational resource requirements; training; transfer of all electronic and hard copy data, documentation, files and other records, including data file loads for testing and conversion to the new Contractor; and inventory and transfer of incumbent Contractor training materials, current comprehensive Enrollment Broker policy and procedures manuals, brochures, pamphlets, and all other written materials developed in support of this RFP for the orderly and controlled transition of the Contractor's responsibilities.

b. Transfer of electronic and hard copy data, documentation, files, and other records shall include, but not be limited to:

    1. Internal records of managed care program benefit adds and changes
    2. MCO Complaint Documentation
    3. Pending Grievances, including Department Appeals and hearings
    4. Pending fraud and abuse referrals
    5. Call Recordings

    DMAS will:

1. Coordinate communications and act as a liaison between the new Contractor and the incumbent Contractor;
2. Work with the Contractor to review and finalize the implementation plan for the Transition Phase;
3. Coordinate the transfer of files and applications from the incumbent Contractor to the new Contractor on a schedule outlined in the approved implementation plan (Transition Phase Activities);
4. Provide all available relevant documentation on operations currently performed by the incumbent Contractor and DMAS;
5. Establish protocols for problem reporting and controls for the transfer of data or information from the incumbent Contractor to the new Contractor;
6. Assign a DMAS liaison to participate in Contractor work groups;
7. Review and approve procedures and protocols defined by the work groups; and
8. Monitor progress through periodic status reports, weekly meetings, and work plan updates.

The Successor Contractor Shall:

1. Finalize the implementation plan, including the Transition Phase Activities and submit it to DMAS for approval;
2. Work with DMAS to establish communication protocols with DMAS and the incumbent Contractor;

3. Attend weekly meetings throughout the Transition Phase to discuss and resolve transition issues and establish procedures and protocols to support operations and promote communications among all parties;
4. Work with DMAS to establish project management and reporting standards;
5. Submit periodic written status reports on the progress of tasks compared to the approved plan including Transition Phase Activities; and
6. Conduct periodic status meetings with DMAS. The new Contractor shall be responsible for preparing the agenda for meetings and preparing and distributing minutes, to include action items, from each meeting.

3.31 Transition upon Termination or Expiration

At the expiration of this contract or at any time the Department desires a transition of all or any part of the duties and obligations of the Contractor to the Department or to another Vendor after termination or expiration of the contract, the Department will notify the Contractor of the need for transition. Notice will be provided at least 60 calendar days prior to the date the contract will expire or at the time the Department provides notice of termination to the Contractor. The transition process will commence immediately upon notification and shall, at no additional cost to the Department, continue past the date of contract termination or expiration if, due to the actions or inactions of the Contractor, the transition process is not completed before that date.

If delays in the transition process are due to the actions or inactions of the Department or the Department's newly designated Vendor and the subsequent Vendor is unable to assume operations on the planned date of transfer, the Department and Contractor will negotiate, in good faith, a contract modification for the Contractor to continue to perform operations on a month-to-month basis and for the conduct of, and compensation for, transition activities after the termination or expiration of the contract. The Department will withhold final payment to the Contractor until transition to the new Contractor is complete.

Notice of termination, cancellation, or expiration of this contract shall not relieve the Contractor of its obligation to process enrollments and meet all contract obligations prior to the effective date of termination, cancellation, or expiration.

Notice of termination, cancellation, or expiration of this contract shall not relieve the incumbent Contractor of the responsibility to provide assistance in the transitioning of services in accordance with the requirements of this contract.

3.32 Close Out and Transition Procedures

a. Within 10 business days after receipt of written notification by the Department of the initiation of the transition, the incumbent Contractor Shall provide to the Department detailed electronic and hard copy documents, files, and other records as stated in Section 10, including data file loads for testing and conversion to the new Contractor.

b. Within 10 business days after receipt of the detailed document, the Department will provide the incumbent Contractor with written instructions, which shall include, but not be limited to, the following:

   1. The packaging, documentation, delivery location, and delivery date of all records, data, and review information to be transferred. The delivery period shall not exceed 30 calendar days from the date the instructions are issued by the Department.

   2. The date, time, and location of any transition meetings to be held between the Department, the incumbent Contractor and any incoming Contractor. The incumbent Contractor shall provide a minimum of 4 individuals to attend the transition meetings and those individuals shall be proficient in, and knowledgeable about, the materials to be transferred, including but not limited to payroll processing, taxes, information technology, and Customer Services.

c. Within 5 business days after receipt of the materials from the Contractor, the Department shall submit to the Contractor, in writing, any questions the Department has with regard to the materials transferred by Contractor. Within 5 business days after receipt of the questions, the Contractor shall provide written answers to the Department.

d. All copyright and patent rights to all papers, reports, forms, materials, creations, or inventions created or developed in the performance of this contract shall become the sole property of the Department. On request, the Contractor shall promptly provide an acknowledgment or assignment in a tangible form satisfactory to the Department to evidence the Department's sole ownership of specifically identified intellectual property created or developed in the performance of the contract.

e. At the end of the contract, the Contractor shall transfer the toll-free number(s), database information, and any web-based resources, including the website, back to the Department. Upon termination of the contract, the Department shall pay the Contractor the value of services performed up to the date of termination, not to exceed the total value of the contract.

3.33 MEDALLION 3.0 Program Specific Requirements

3.33.1 Medallion 3.0 Enrollment Procedures

Managed Care eligible Medicaid individuals will be assigned to a MCO by the Department or added by the Contractor. For newly eligible Medicaid individuals, this occurs within 30 days after Medicaid eligibility is entered into VaMMIS. Prior to managed care plan assignment, the member is in FFS Medicaid.

Managed care processing for the Medicaid program runs twice a month, at midmonth on the night of the 18th and at the end of the month (EOM) on the night of the last day of the month. Current, newly enrolled, as well as reinstated Medicaid individuals are evaluated for managed care eligibility based on a set of rules. The midmonth process validates existing enrollments and assigns Medicaid individuals who are not currently enrolled to an MCO. The EOM process validates existing enrollments and re-enrolls Medicaid individuals back into the same MCO for updates made after midmonth processing. Managed care assignments only occur

during midmonth processing and they are always prospective, beginning the first of the next month (except for newborns). The MCOs receive an 834 file after midmonth processing and a final 834 after EOM processing with their enrollment roster for the following month.

In August 2014 program changes were implemented to expedite enrollment into the managed care program. This new process streamlines enrollment, moving Medicaid individuals into an MCO more quickly, while still providing the opportunity for choice. Medicaid individuals benefit as they have quicker access to care coordination and services provided by the MCOs that are not available under straight Medicaid fee-for-service.

A new notification and information letter was created for newly enrolled Medicaid individuals. When a Medicaid individual is enrolled, a nightly program runs in the MMIS to determine if they are likely managed care eligible based on the information entered. Medicaid individuals who meet the managed care criteria receive a system generated letter informing them of the begin date for their managed care enrollment and the opportunity to select a managed care plan by contacting the Managed Care Helpline. The Contractor has the responsibility to add managed care benefits for Medicaid individuals who call and select a plan.

Midmonth managed care processing will validate current enrollments and assign Medicaid individuals who are eligible and not currently enrolled. Medicaid individuals are assigned to an MCO based on an algorithm. The algorithm assigns members first by previous individual MCO assignment, then by family (case) history. Finally, the individual is assigned randomly, which is done by case in an effort to keep Medicaid individuals in the same family together in the same MCO. This MCO assignment process ensures continuity of care by assigning individuals using prior enrollment history with an MCO.

MCO assignment letters are sent by the Department's mailing contractor. The letter identifies the assigned MCO for each Medicaid individual in the household/case and includes a comparison chart of which MCOs participate by locality in the Medicaid individual's managed care region. The letter also provides the time frame for the Medicaid individuals to call the Contractor to change their selection. If the Medicaid individual does not call to make a change, the assignment is effective as of the begin date in the letter (the first of the following month). Medicaid individuals who move during the month and reside in a different managed care region will also receive an assignment letter and comparison chart as they may have been assigned to a new MCO or have different MCO plans available. The mailing vendor is required to mail the letters within 3 business days after receipt of the file.

MCO Medicaid individuals have until the last business day of the month before the begin date and a 90-day window from initial enrollment without cause to make a change for any reason. All Medicaid individuals have an annual 60 day open enrollment period which is by region. After the begin date, the Medicaid individual must make an MCO change on or before the last business day before the 18thto make a change for the next month. After the 18th of the month, a change can be requested but will not be effective until the month after the following month. Medicaid individuals may elect to change to another MCO, where there was no prior assignment to that MCO, and receive another 90 day trial period.

DMAS reserves the right to utilize alternate assignment/enrollment strategies when there are expansions to new Medicaid or Medicaid managed care eligible populations. It is important to note, however, that approximately 80% of all individuals accept the assignment made by the Department and do not call the HelpLine to change their MCO health plan.

If an MCO Medicaid individual loses Medicaid eligibility, and that eligibility is regained after the 18th of the month, managed care eligibility processing re-enrolls the Medicaid individual back to their previously assigned MCO plan. If the re-enrollment is in a different managed care region, the Medicaid individual will receive a letter from the mailing contractor with a comparison chart advising the individual that they can select a different plan that may now be available. The Medicaid individual has the same 90 day window as a new assignment to select a different plan. A Medicaid individual cannot be re-enrolled at the end of the month if they have moved and their current MCO does not participate in the locality where they now live. These Medicaid individuals will be in FFS for a month until they are assigned during the midmonth process the following month.

Neither the Managed Care HelpLine nor the DMAS managed care unit can expedite enrollment back to managed care and/or retro-enroll Medicaid individuals back to the same MCO. All assignments are prospective. Medicaid individuals will need to contact the DMAS Recipient HelpLine for temporary FFS coverage issues.

MCOs are notified of the Medicaid individuals assigned to their health plan by the Department twice a month; once at mid-month around the 20th and after the last day of each month around the 2nd of the month. The MCO sends their newly enrolled Medicaid individuals a MCO packet: including introduction letter, a MCO identification card, Medicaid individual handbook and/or Evidence of Coverage (EOC). Some MCO plans may send extra material such as magnets, brochures, etc. Upon disenrollment from a plan, the MCO shall notify the Medicaid individual through a disenrollment notice that coverage in the MCOs plan will no longer be effective.

EXAMPLE TIMELINE FOR ENROLLMENT PROCESSING

Timeline	Activity
Day 7	Medicaid eligibility determined/eligibility entered into MMIS by DSS staff/letter program rules determine if MCO eligible/system generated form letter, enrollment broker (EB) phone # and MCO begin date
Day 12	Medicaid individual receives letter and contacts EB with MCO choice/EB adds benefit, enters MCO choice and begin date in MMIS as first day of next month
Day 18	MCO assignment rules run, if MCO eligible, algorithm assigns MCO and generates mid-month 834 report to MCOs/MMIS produces letter file for mailing vendor
Day 20	Mailing vendor mails assignment letters to Medicaid individuals
Day 30	Medicaid individual has until last business day of month to change MCOs and be effective for the 1st of following month/MMIS runs end of month rules to generate end of month

	834 report to MCOs
Day 1 of New Month	MCO Medicaid individual enrollment begins
Day 2 of New Month	MCOs begin sending member packets based off EOM 834

The Contractor must provide information to Medicaid individuals who call after the 18th but before the end of month, for example - if the Medicaid individual gets 2 ID cards, or explaining to a Medicaid individual how to receive services between the 1st of month and the date they receive their MCO card. The Contractor shall provide a call script to DMAS for approval.

3.33.2 MEDALLION 3.0 Open Enrollment

A twelve-month managed care enrollment period is part of the Medicaid program. The Department has five regional annual open enrollment periods designated by the area of the state where the Medicaid individuals live (see table below). Each enrolled individual receives 60 days notice by mail prior to new effective date to change MCOs. The Contractor is responsible for complying with the guidelines established for changing MCOs and must have appropriate systems in place to ensure health plan changes are made within the appropriate allowable time frames. The Contractor must ensure that call center staff are educated about the six open enrollment periods over the course of 12 months. Refer to Attachment XVI for more details.

The 6 designated open enrollment periods for Managed Care Medicaid individuals are listed as follows:

Managed Care Open Enrollment			
Region	**Letter Sent (End Of Month)**	**Call Time**	**Effective Date**
Central Virginia	January	Feb-Mar	Apr 1
Tidewater/Far Southwest	April	May-June	July 1
Northern Virginia/Winchester	June	Jul-Aug	Sept 1
Western	August	Sept-Oct	Nov 1
Roanoke/Alleghany	November	Dec-Jan	Feb 1
Far Southwest	April	May-June	July 1

3.34 Exclusion from MEDALLION 3.0 Managed Care Enrollment

Medicaid individuals eligible for managed care enrollment who are in assignment may request exclusion from managed care. Managed care exclusions will be handled by the Department in accordance with the Department's criteria. The Contractor must submit requests and accompanying documentation to the Department for processing. At minimum, this information includes the Medicaid individual name, Medicaid ID#, caller/requester name, phone number, and the reason for the

exclusion request. There is a designated form to capture exclusion requests. (Refer to Attachment XVII) The Contractor can send this form to DMAS via secure email or by fax. The Department will send a response to the exclusion request to the Medicaid individual within 15 days. Managed care exclusions are provided for the MEDALLION 3.0 program as Attachment XVIII of this RFP and in the MCO contract at http://www.dmas.virginia.gov/Content_atchs/mc/mc-mdl2_cntrct710.pdf.

3.35 MEDALLION 3.0 Disenrollments, Re-enrollments and Plan Changes

The Contractor shall be responsible for the disenrollment and re-enrollment of managed care Medicaid individuals from one MCO to another, according to guidelines set forth by the Department for each population in Medicaid. The Contractor shall develop a system to assign reason codes for disenrollments, in accordance with Department standards. The Contractor must be able to modify the reason codes to meet the Department's specifications. The Contractor shall provide the Department an updated list of reason codes as modifications.

In instances of disenrollment and plan changes, the Contractor shall make a bona fide effort to determine the reason for disenrollment or plan change and clearly document the reason in the Contractor's system for future reference in determining and addressing quality issues. The Contractor shall submit a health plan change report to the Department monthly. Refer to Attachment XV for a list of MCO change reasons. When there appear to be alternatives to disenrollment or plan changes, the call center staff must inform the Medicaid individual of the available options to enable the Medicaid individual to make a more informed decision.

3.36 MEDALLION 3.0 Enrollment Transfers

The Department may terminate a health plan contract or may remove a portion of an MCO's enrollees and transfer them to other plans or reassign them to other plans. In these cases, the Department will handle enrollment transfers systematically via the automated pre-assignment process as previously described. The Contractor shall handle calls from Medicaid individuals that transfer to a different participating MCO within existing program rules as described in 3.35 above.

3.37 MEDALLION 3.0 Enrollment Materials

3.37.1 Comparison Charts and MCO Brochures

The Contractor is responsible for designing, printing and maintaining adequate stock of comparison charts and MCO brochures for the Medicaid MCO program. The current Regional charts include Central Virginia, Tidewater, Northern and Winchester, Western, Roanoke/Alleghany and Far Southwest. Copies of current comparison charts and MCO brochures are available on the DMAS website at http://www.dmas.virginia.gov/Content_pgs/mc-home.aspx and for the CCC Program at http://www.virginiaccc.com/English/charts.html.

3.37.2 Enrollment Materials for Cover Virginia

The Contractor is responsible for providing the "Cover Virginia" call center contractor with MCO charts as requested. The Contractor will receive a weekly inventory sheet from the contractor responsible for FAMIS enrollment broker services via the enrollment broker Contract Administrator and requests from the contractor responsible for FAMIS enrollment broker services for additional charts will be filtered through DMAS to the enrollment broker on a weekly basis. The Contractor should maintain an inventory and delivery every three months. When a new chart is revised, the enrollment broker shall replenish the inventory.

3.37.3 Fulfillment Packets

A fulfillment packet is defined as enrollment material as requested by the enrollee. A fulfillment packet includes MCO comparison charts, MCO brochures, or a combination thereof. Fulfillment packets shall be mailed by the Contractor upon request of a Medicaid individual within 2 business days. The Contractor is responsible for all postage costs associated with mailing fulfillment packets. Refer to Attachment IX for additional details.

The Contractor shall develop, modify, print and distribute materials including but not limited to enrollment materials pursuant to guidelines set forth by the Department. Materials shall be revised annually at Open Enrollment. At a minimum, materials shall be provided in English and Spanish.

All materials must be in an easily understandable and culturally sensitive in printed format and in audio-visual format if possible. Medicaid individual information must be at a 6th grade reading level and be clearly legible with a minimum font size of 12 point, unless otherwise approved by the Department. The Department will approve all materials while they are in draft form and may recommend changes in whole or part. The Department should be consulted on all approaches to document development before the final approach is decided upon. The Contractor shall use the same forms and formats, and maintain standardization throughout the materials to the extent feasible. Under special circumstances, the Department may need to modify these materials in addition to the annual changes referenced above. The contractor shall provide DMAS with an electronic copy of printed material.

3.37.4 Printing and Storage of Enrollment Materials

After final approval, the Contractor shall be responsible for printing all written materials; maintaining a sufficient stock of materials on site; and distributing materials as needed at the Contractor's expense to the DMAS mailing contractor. As materials are revised, the Contractor shall provide updated files to the Department's mailing contractor. The Contractor shall also provide a sufficient stock of materials for DMAS staff. In addition, upon request the Contractor shall supply an inventory of comparison charts to the Department's contracted MCOs, the contractor responsible for enrollment broker services for the FAMIS program or for special marketing events, Medicaid individual or provider meetings.

At a minimum, the Contractor shall develop materials that:

- Contain a "worksheet" or checklist on how to select an MCO.

- Explain the difference between fee-for-service and managed care; explain the importance of a "medical home" and coordinated health care.
- Develop comparison charts for managed care programs, customized to the specific and intended audience.
- Promote the delivery of services in a culturally competent manner to all Medicaid individuals including those with limited English proficiency and diverse cultural and ethnic backgrounds.
- Describe services covered through the managed care programs, including EPSDT services, with emphasis on preventive health care for adults and children.
- Encourage Medicaid individuals to maintain appropriate existing provider relationships or to otherwise make their own choice of a PCP.
- Compare MCO plans and programs via a comparison chart; it is the responsibility of the Contractor to update the chart once per year prior to open enrollment. The chart shall include list of counties and cities, participating MCOs, contact information (phone numbers and website), list of hospitals and extra programs and services.
- Update comparison charts with new health plan information as needed (such as MCO name change), other than the required annual revisions, at the expense of the requesting health plan.
- Educate Medicaid individuals regarding services that may be furnished without referral from the PCP, such as family planning, and ways to access such services.
- Educate Medicaid individuals regarding the proper use of emergency departments.
- Inform Medicaid individuals about how they may access behavioral health and substance abuse services and other special health care service needs.
- Inform Medicaid individuals of the managed care appeal and grievance processes.
- Inform Medicaid individuals about Medicaid-authorized transportation services.
- Inform Medicaid individuals about the DMAS Managed Care websites for the MEDALLION 3.0 program and the Commonwealth Coordinated Care Program: http://virginiamanagedcare.com/ for the MEDALLION 3.0 program and http://www.virginiaccc.com/default.html.

All written material shall be printed with the assurance of non-discrimination on the grounds of handicap, and/or disability, age, race, color, religion, gender, or national origin.

The Contractor shall not include the following on any written materials, including but not limited to educational materials, without the approval of DMAS:

a. The Seal of the Commonwealth of Virginia
b. The word "free" can only be used if the service is at no cost to all Medicaid Individuals

As a part of the Technical Proposal Response to this RFP, the Offeror must submit information reflective of the Offeror's proposed technology and capability to follow the requirements described in this RFP.

3.38 Health Status Survey Questionnaire for the MEDALLION 3.0 Program

The Health Status Assessment and Survey Questionnaire (HSA) is a list of health related questions designed to establish the Medicaid individual's basic health status and assist the Medicaid MCO in identifying areas of concern and resource referrals for the MEDALLION 3.0 program. It is also designed to establish the impact of managed care on the overall health status of the managed care population. It is mandatory that the Contractor complete an HSA for all MEDALLION 3.0 eligible Medicaid individuals who are newly enrolled or when a Medicaid individual calls to change from one MCO to another. The Contractor shall communicate to the caller why personal health questions are being asked and ensure the Medicaid individual that the information gathered is strictly confidential and will be shared only with the MCO. The HSA is subject to significant revision by DMAS and may be revised during the implementation process for this contract.

The HSA is placed on a Secure FTP weekly and MCO picks up file for their use in planning the care of the Medicaid individual. The information is used only by the MCO to follow up or outreach to the individual or case head to make sure the individuals needed care; treatment or medications are not interrupted. A sample HSA is provided as Attachment VI; HSA monthly volume is provided as Attachment VII.

The HSA development and administration requirements are as follows:

- The Contractor shall work with the Department to develop and modify the HSA tool. In addition to determining the health status of the Medicaid individual, the tool must specify any on-going treatments, pre-authorized services, or authorized durable medical equipment currently utilized by the Medicaid individual, which would necessitate coordination of care on the part of the MCO. The survey tool will also assist the MCOs in arranging and continuing care for Medicaid individuals with special health care needs.
- The Contractor shall complete a HSA on each Medicaid individual individually in the case.
- For auditing purposes, the Contractor shall administer the HSA tool and maintain the original or electronic copies of the original.
- The Contractor shall administer the HSA as age appropriate in a manner sensitive and responsive to each Medicaid individual's circumstances.
- The Contractor shall review the HSA results with the Medicaid individual to enable the Medicaid individual to make an informed choice regarding a MCO to best meet his/her needs.
- After final enrollment, Contractor shall forward a copy of the HSA to Contractor's FTP/Xchange Server weekly (the beginning of the following week); with this method, the Contractor can control the files and information, once posted, including the ability to delete a file if posted in error. The MCO will be responsible for picking up weekly HSA file from their individual outbound folder.
- The Customer Service Representative must inform Medicaid individuals who have on-going medical conditions of the need to contact the MCO to arrange for coordination of care.
- The Contractor shall work with the Department to review and update the HSA tool, as needed.
- The Contractor shall obtain the callers current phone number to ensure MCOs will have the ability to contact Medicaid individuals for care coordination efforts.

3.39 MEDALLION 3.0 Managed Care Compliance Reporting

The contractor shall provide administrative support to the DMAS Health Care Services Division to assist the Division with user friendly reports and decision matrices for MCO monitoring and reporting

requirements as outlined in the MCO contract located at: http://www.dmas.virginia.gov/Content_atchs/mc/mc-mdl2_cntrct710.pdf. The following contract compliance functions shall be included in the proposal:

A. **Access to Care and Network Standards Reporting** – Develop, implement and submit monthly a Provider network verification report that accepts weekly provider network updates from MCO/MMP plans participating in the programs under this contract. MCO/MMP networks for each participating plan will include acute care hospitals, outpatient clinics, specialty and primary care providers and other provider class types as determined by DMAS. The contractor will carry out network adequacy analysis using this database based on parameters set by the department that will include geo mapping and will include a robust reporting process that determines which service areas lack adequate provider access by specialty and level of care and will MCO to MCO comparison.

B. **Provider Oversight Reporting** – develop, implement and submit monthly a reporting template/decision matrix that compares provider relations contract section requirements with MCO information and data submitted monthly, which also compares this information across MCO plans for plan to plan comparisons. These contract requirements include anti-discrimination, provider education, disenrollment, physician incentives, ineligible providers, provider satisfaction surveys, provider inquiry performance standards, provider advisory committee specifications, and contractor referral responsibilities

C. **Member Outreach and Marketing Service Reporting** – develop, implement and submit monthly a reporting process template/decision matrix that compares member outreach and marketing services contractual requirements with MCO information and data submitted monthly, which also compares this information across MCO plans for plan to plan comparisons. These contractual requirements include new member packets, member identification cards, member handbooks, member rights, cultural competency, member services and member education.

D. **Benefit Service Requirements and Limits** – develop, implement and submit monthly a reporting template/decision matrix that compares benefit service requirements and limits required in the MCO contract with MCO data and information submitted monthly, which also compares this information across MCO plans for plan to plan comparisons. These contractual requirements include cost sharing, court-ordered services, coverage of authorized services, early and periodic screening, diagnosis and treatment requirements, early intervention services, medical necessity criteria, scope modifications of covered services, moral or religious objections, notifications of sentinel events, out of network and out of state services, pharmacy utilization management programs, primary care management programs, second opinions, at risk populations and utilization management/authorization program descriptions.

E. **Financial Management Reporting** – develop, implement and submit monthly a reporting and template/decision matrix that compares financial management contractual requirements with MCO data and information submitted monthly, which also compares this information across plans for plan to plan comparisons. Financial records include solvency documentation, financial statements, changes in reserves, recoupment/reconciliation, payments using DRG methodology or other health care payment methodologies, payments for newborns, billing members for covered services and

medically necessary services, third party liability, limits on underwriting gain and administrative costs, "never events" and health care acquired conditions, primary care physician payments, FQHCs and RHCs, disproportionate share hospital recoupment and certification of non-encounters.

3.40 MEDALLION 3.0 Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Information

The EPSDT program is Medicaid's comprehensive and preventive child health program for individuals under the age of 21. EPSDT was defined by law as part of the Omnibus Budget Reconciliation Act of 1989 (OBRA 89) legislation and includes periodic screening, vision, dental and hearing services. In addition, the Social Security Act requires that medically necessary health care services be provided to an EPSDT Medicaid individual even if the service is not available under the state's Medicaid plan to the rest of the Medicaid population. Under EPSDT, Medicaid children have access not only to well child visits, but also lead testing, developmental screenings, personal care, nursing, hearing aids, and specialized mental health and rehabilitative services for complex neurological and physical health conditions. Details regarding EPSDT such as fact sheet, brochure and birthday newsletters can be accessed at http://www.dmas.virginia.gov/Content_pgs/mch-home.aspx.

The Department routinely sends notices to EPSDT eligible Medicaid individuals (MCO and Fee for Service) as a means of educating them of necessary and available services as well as how to access these services. These materials describe:

- The benefits of preventive health care and the importance of having a PCP;
- Medical screenings, including immunizations, vision, hearing and dental screenings;
- The importance of staying up to date with well child visits and vaccines/immunizations;
- Information on when screenings are due for their child(ren);
- Information on the importance of lead testing; and,
- Information on how to access these services.

At a minimum, the Contractor shall:

- Advise managed care Medicaid individuals of EPSDT; the importance of keeping up with well child care visits and immunizations; and that these services are covered at no cost to the enrollee;
    - Include links (English and Spanish) to the Department's Staying Healthy web-page, http://www.coverva.org/main_staying_healthy.cfm as well as links to other helpful websites and/or EPSDT resource information as requested and/or approved by the Department.
- Refer Medicaid individuals to the appropriate entity MCO or DMAS for special assistance.

In addition, the table below highlights the types of letters that are currently sent by DMAS.

EPSDT Letter Type
EPSDT Welcome Letter – sent to new Medicaid children under age 21.
Monthly Birthday Cards/Newsletter – sent to Medicaid individuals in the Medicaid program during

the month of their birthday. These letters educate children and their parents about the EPSDT program, the importance of keeping up with well child visits and immunizations.
Lead testing and elevated blood lead notices – In collaboration with the Virginia Department of Health, the Department receives information from VDH on children who have been screened and found to have elevated lead levels. These letters are sent to urge parents to proceed with follow-up testing.
Lead letter # 2 – These letters are sent as a reminder and follow-up, to the parents of a subset of the children identified for the letter above, where statistics indicate that the child remains in need of follow-up testing.

3.41 Commonwealth Coordinated Care Program Specific Requirements

The 2012 Appropriations Act directed and authorized DMAS to develop and implement a care coordination model for individuals eligible for Medicare and Medicaid (dual eligibles). The primary responsibilities of the Contractor for the Commonwealth Coordinated Care Program (CCC) are to support and maintain the (CCC) program which is part of the Governor's Medicaid Reform initiatives. A main component of this program is to have an enrollment broker for enrollees and eligible beneficiaries. Medicaid individuals eligible for or enrolled in the CCC program shall be included in the population served by this RFP. All RFP requirements shall be applicable to the CCC population. In the event that there is a conflict between RFP requirements and Section 3.41 Commonwealth Coordinated Care Program requirements, the requirements of Section 3.25 shall apply. The Contractor shall provide the following CCC services:

- Medicare/Medicaid Plan (MMP) enrollment broker services including updating materials such as: job aids, FAQ's, enrollment processes, will manage the process of enrolling eligible beneficiaries into MMPs by use of the VaMMIS, and increase the knowledge of staff to fulfill all required tasks;
- Provide graphic design and printing of MMP Comparison Charts for each CCC region which contains all MMPs standard and extra services that are provided to eligible consumers and identifies the MMPs participating providers;
- Develop and maintain a static website page owned and controlled by DMAS with specific, up-to-date educational information and operable links to support the CCC population that is separate and distinct from the DMAS Medicaid Managed Care website;
- Answer incoming calls to a dedicated 800 number owned and controlled by DMAS for this program to educate and enroll eligible beneficiaries into managed care plans (see Attachment XX for example of CCC Call Center Statistical Report). This 800 number is separate and distinct from the DMAS Managed Care Helpline 800 number;
- Process enrollments received by mail and incoming faxes;
- Develop, implement, and maintain a letter file process to send, track, and report mailings of letters,
- Process daily file merge for staff to enter VaMMIS transactions and send mailings identified by Daily Transaction Reply Report (DTRR) action codes;
- Transaction codes (TC) are associated with approximately twenty-three (23) exhibits that are mailed to consumers based on the outcome of the electronic return process of the Daily Transaction Reply Report (DTRR), CMS is the originator of the DTRR reporting system; The offeror must comply with all CMS mandated requirements within required timelines

- All mailings, communications, and materials for consumers including educational materials shall be worded at 6th grade reading level unless otherwise approved by CMS and DMAS;
- Transaction Codes (TC) and Transaction Reply Codes (TRC) from CMS DTRR that does not automatically update in VaMMIS, the enrollment broker shall ensure that the VaMMIS is up-to-date with current data consistently. For example, but not limited to, the DTRR reports a TC51/TRC014, which indicates that a beneficiary Opt-out of the CCC program by calling 1-800-MEDICARE, which requires the enrollment broker to enter this action into VaMMIS manually.

3.41.1 CCC Enrollment Processes

The Contractor shall have the systems in place, policies and procedures to accept enrollment and disenrollment requests into the Commonwealth Coordinated Care (CCC) program via paper and telephonic means. The Contractor shall also have a process and sufficient and knowledgeable staff to enter MMIS transactions and send mailings in a timely and accurate manner in response to DTRR action codes.

3.41.2 For Opt-in/Voluntary Enrollment (Flow Diagram 1 - Attachment XXI)

When an eligible beneficiary chooses to enroll in the CCC program and when sufficient information is received to approve the enrollment, the Contractor shall:

Enroll the eligible beneficiary in the CCC benefit package and then either complete Option A or Option B below:

A. Option A: Send an acknowledgement of completed enrollment within 10 calendar days of enrollment request and send a notice to confirm enrollment within 10 calendar days of the receipt of the DTRR; or
B. Option B: Send a combined acknowledgement of completed enrollment request and completed enrollment to confirm enrollment within 7 calendar days of receipt of the DTRR.

When an eligible beneficiary chooses to enroll in the CCC program (via paper request), but additional information is needed, the Contractor shall send a letter requesting additional information within 10 calendar days of the enrollment request. The eligible beneficiary will have 21 days to reply.

A. If the eligible beneficiary's enrollment is eventually approved, then the Contractor shall follow the steps outlined above.
B. If the eligible beneficiary's enrollment is eventually denied, then the Contractor shall send a denial letter with appropriate appeal information within 10 calendar days of receipt of the enrollment request or the end of the time frame for pended information.

3.41.3 For Opt-Out/Voluntary Disenrollment (Flow Diagram 2 - Attachment XXI)

If an eligible beneficiary opts-out of the CCC program and was never enrolled, the Contractor shall:

A. Change the indicator from "E" to "O" to opt-out in the MMIS.
B. Send a letter confirming the decision to opt-out within 10 calendar days of request or DTRR.
C. Assign opt-out as the indicator in the MMIS so the eligible beneficiary remains out of passive enrollment and doesn't receive future letters.

If an enrollee had opted-in or was passively enrolled into the CCC program and is receiving services from a MMP, upon receiving a disenrollment request, the Contractor shall assess whether the disenrollment request is complete or incomplete.

A. If the disenrollment request is complete, the Contractor shall:
    1. End the CCC benefit package in the MMIS; and
    2. Send confirmation of the request to disenroll within 10 calendar days of receipt of request.

B. If the disenrollment request is incomplete, the Contractor shall:
    1. Notify enrollee within 10 calendar days to specify what additional information is needed. Information must be received by the end of the month or within 21 calendar days (whichever is later).
    2. If the information is received within the requested timeframe, the Contractor shall:
        - End the CCC benefit package in the MMIS; and
        - Send confirmation of the request to disenroll within 10 calendar days of receipt of request.
    3. If the information is not received within the requested timeframe, the Contractor shall not process the request and the enrollee shall remain enrolled in the MMP.
    4. The Contractor shall implement an encoding system to track the enrollee's reason for voluntarily disenrolling from the CCC program or a specific MMP.

3.41.4 For Cancellation of Voluntary Enrollment/Disenrollment Requests (Flow Diagram3-Attachment XXI)

If an enrollee decides to cancel his/her enrollment request to the CCC program (after having opted in), the Contractor shall follow the appropriate procedures outlined below:
If the enrollment transaction has already been sent, the Contractor shall:

A. Within 10 calendar days of receipt of request to cancel, send the enrollee a letter to acknowledge cancelation.
B. Assign the opt-out indicator in the MMIS if the eligible beneficiary chooses to disenroll from all future passive enrollments.
    Note: If the cancelation request is rejected (via the DTRR), retro-active processor is contracted, comes back on the DTRR, and the CMS contractor shall inform DMAS.

If the enrollment transaction has not been sent, the Contractor shall:

A. Send the eligible beneficiary a letter to acknowledge cancellation within 10 calendar days of receipt of request to cancel.

B. Assign the opt-out indicator in the MMIS if the eligible beneficiary chooses to disenroll from all future passive enrollments.

If an enrollee decides to cancel his/her enrollment request (after they have opted-in) to the CCC program, but they are actively enrolled in a MMP, the Contractor shall inform the enrollee that he/she cannot be canceled and follow the opt-out/voluntary disenrollment procedures in Flow Diagram 2 outlined above.

If an enrollee decides to cancel his/her disenrollment request, the Contractor shall cancel the disenrollment request procedures based on the following appropriate scenario:

A. If the disenrollment transaction (51) was sent, the Contractor shall send a letter notifying the enrollee that he/she is back in the CCC program after the DTRR is posted. Note: If the cancellation request is rejection, CMS' retro-active processor is contacted, comes back on the DTRR, and the Contractor shall inform DMAS.

B. If the disenrollment transaction (51) was not sent, the Contractor shall:
   1. Send the enrollee a letter to acknowledge cancellation within 10 calendar days of receipt of the request to cancel.
   2. Create a new line for enrollment.

C. If the enrollee will already be disenrolled after the end of the month, the Contractor shall notify the enrollee that he/she has already been disenrolled and then follow the re-instatement processes (Flow Diagram 5, if appropriate).

3.41.5 Involuntary Disenrollment (Flow Diagram 4 - Attachment XXI)

In the event that an enrollee needs to be involuntarily disenrolled from the CCC program, the Contractor shall follow the steps outlined in the table below, depending on the reason for involuntary disenrollment.

Reason for Involuntary Disenrollment	Steps The Contractor Shall Follow
Enrollee permanently moves out of the duals FIPS	• End the CCC benefit package in the MMIS • Send notification to the enrollee within 10 calendar days of the notice of the change of address.
Change of address/Unable to locate the enrollee for six (6) months	• End the CCC benefit package in the MMIS and • Send notification to the enrollee by the 10th day of the beginning of the 6th months; and,
Potential change in address	• Send request for updated address within 10 calendar days of receiving notification and • [If there is no response from the enrollee by the 1st day of the 6th month] disenroll the enrollee and send notification by the 10th day of the beginning of the 6th month.

Loss of Medicare Part A or Part B	• End the CCC benefit package in the MMIS • Send notice within 10 days of receipt of DTRR or prior to the end of the month, whichever is first.
Loss of Medicaid	• End the CCC benefit package in the MMIS • Send notice within 10 days prior to the disenrollment effective date.
Death Notification from CMS	• DMAS will be responsible for sending Death Notification
MMP contract termination or reduction in MMP service areas	• Help an enrollee switch to another MMP and • End the old benefit package in the MMIS and enter a new CCC benefit package. • If the enrollee fails to enroll in anther MMP, the Contractor shall end the CCC benefit package.
Material misrepresentation or fraud	Upon approval from CMS: • End the CCC benefit package in the MMIS and clear out the indicator and • Send disenrollment notice within 10 calendar days of CMS approval.

3.41.6 Reinstatements (Flow Diagram 5 - Attachment XXI)

In the event that an eligible beneficiary's CCC enrollment needs to be reinstated, the Contractor shall follow the steps outlined below, depending on the reason for reinstatement.

In the case of erroneous death indicator/erroneous loss of Medicare Part A or B indicator/Medicaid, the Contractor shall:

A. Instruct the eligible beneficiary in writing to continue using MMP services within 10 calendar days of the eligible beneficiary's contact with the MMP or with the Contractor.
B. Send a copy of the letter that was sent to the eligible beneficiary to CMS.
C. Send the eligible beneficiary a notification of reinstatement within 10 calendar days of receipt of DTRR confirmation of the eligible beneficiary's reinstatement Transactions Reply Codes (TRC) 713 or 287). [If the DTRR does not confirm reinstatement, the Contractor shall consult with DMAS.]

If an eligible beneficiary contacts the Contractor to cancel new enrollment in another MMP, the Contractor shall:

A. Void the previous MMP change request using cancel reason and enter a new CCC benefit package with previous MMP.
B. Send the eligible beneficiary a letter of reinstatement within 10 calendar days of receipt of DTRR confirmation of the eligible beneficiary's reinstatement.
C. If the reinstatement is not processed timely by CMS' systems, send request to Retroactive Processing Contractor (RPC) and complete documentation to cancel enrollment.

If an MMP, CMS or the State makes an error, the Contractor shall:

A. Cancel disenrollment action from CMS records, if previous transaction submitted to CMS, if the error made meets cancellation criteria effective dates within the parameters/transactions sent;
B. Then follow procedures outlined in Flow Diagram 3.

3.41.7 Optional Involuntary Disenrollments (Flow Diagram 6 - Attachment XXI)

The Contractor shall not have any responsibilities as it pertains to Flow Diagram 6.

3.41.8 Passive Enrollment (Flow Diagram 7 - Attachment XXI)

During passive enrollment:

A. If the eligible beneficiary chooses to opt-in to the CCC program, the Contractor shall follow the procedures in flow diagram 1 outlined above.
B. If the eligible beneficiary chooses to opt-out, the Contractor shall follow the procedures in Flow Diagram 2 outlined above.
C. If the eligible beneficiary doesn't make a decision, and becomes passively enrolled in a MMP, but the eligible beneficiary changes MMP selection close to the end of the month, the Contractor shall send a change report to the previously chosen MMP.

3.41.9 Retro Enrollment Flow (Flow Diagram 8 - Attachment XXI)

The Contractor shall not have any responsibilities as it pertains to Flow Diagram 8.

3.41.10 Compliance with Memorandum of Understanding

The Contractor shall have systems in place, policies, and procedures and internal controls to ensure compliance with all enrollment/disenrollment and related requirements in the Memorandum of Understanding (MOU) and the three way contract with CMS and the Commonwealth of Virginia and staying up-to-date on all changes.This (MOU) is available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/VAMOU.pdf

3.41.11 Medicare-Medicaid Plan Enrollment and Disenrollment Guidance

The Contractor shall have systems in place, policies, and procedures and internal controls to ensure compliance with the Medicare-Medicaid Plan Enrollment and Disenrollment Guidance (dated June 14, 2013) and staying up-to-date on all changes. This document is available at http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MMPFinalEnrollGuidance.pdf

3.41.12 Medicare-Medicaid Plan Three (3) Way Contract

The Medicare-Medicaid three way contract contains a mutual agreement with U.S. Department of Health and Human Services (HHS), Center for Medicare and Medicaid Services (CMS) and the Department of Medical Assistance Services (DMAS); this document is available at http://www.dmas.virginia.gov/Content_pgs/valtc.aspx

3.41.13 CCC IT Data Exchange with DMAS and Fiscal Agent

The Contractor shall retrieve the DTRR batch file from DMAS and/or its fiscal agent that will be located on a secure server. The DTRR batch file which will consist of Enrollment Detail records (identified by their Health Insurance Claim Number (HICN) in a corresponding comma delimited text format (also referred to as a comma separated value (CSV) file). The Contractor shall also accommodate not having a file to process on any given day, which could also occur (there may not be a daily file transmitted even though the name suggests that it is a "Daily" transmission).

4. REPORTING AND DELIVERY REQUIREMENTS

4.1 Standardized Reports

The Contractor shall maintain data necessary to complete all reports specified in this RFP. For purposes of this section, reports are defined as regularly scheduled submissions that the Contractor is required to provide to the Department so that the Department can monitor the Contractor's performance and meet state or federal reporting requirements. The Contractor shall submit timely, accurate, and complete management reports to the Department at the specified intervals. All reports, analyses, and/or publications generated under this contract shall be the property of the Department.

The Contractor shall develop and maintain a variety of standardized reports including a monthly, quarterly and annual contract report, and ad hoc reports that contain required data. The report formats shall be sufficiently flexible to enable comparison of data elements and be provided in electronic and/or paper format as determined by the Department. Reports shall measure achievement of contract performance standards and include, but not be limited to, statistics for the following areas: volume of calls, calls by category, average length of time of calls, average wait time, staff hours available, abandonment rate, average length in queue, comparison of data with prior weeks and months and other information stipulated by DMAS. Reports shall be cumulative, provide trend and comparison data, and have quarterly and annual summaries. All reporting errors shall be immediately corrected by the Contractor and resubmitted to the Department.

The Contractor shall generate two sets of reports, one set of reports for the CCC program/enrollee population and one set of reports for the MEDALLION 3.0 program/enrollee population unless otherwise noted.

The Offeror shall demonstrate experience in data collection and analysis and in writing reports that are well organized, clear, concise and readable by laypersons.

4.2 Operations Reports

Contractor Operations reports shall provide detailed weekly, monthly, quarterly, and annual data as determined by the Department. Data shall be cumulative and reflect trends through tables, charts or graphs. The Department reserves the right to modify the frequency, format, and data requirements of any report, as necessary.

Operations reports shall measure contract performance standards; be submitted weekly for the first three months of implementation and as determined by the Department thereafter. Reports shall include, but not be limited to, the following:

a. Ad Hoc Reports

   The Contractor shall provide ad hoc reports as requested and prioritized by the Department. Ad hoc reports shall be delivered within mutually agreed upon timelines and provided in mutually agreed upon formats. The Department will incur no expense in the generation of ad hoc reports. The Department expects that standardized reports described within this contract will minimize the need for ad hoc reports.

b. Audited Financial Statements and Income Statements

   The Contractor shall provide to the Department copies of its annual audited financial (or fiscal) statements no later than 90 calendar days after the end of the calendar year.

c. Public Filings

   The Contractor shall promptly furnish the Department with copies of all public filings, including correspondence, documents, and all attachments on any matter arising out of this RFP.

d. Other Reporting Requirements

   As distinct from ad hoc reports, any additional data required or data changes needed to meet federal or State reporting and evaluation requirements will be required of the Contractor. These changes shall be handled as a maintenance activity and the Department will incur no expense for such reports. The Department will provide written notice of requested revisions.

e. Quarterly Quality Assurance Reporting (See Requirements in Attachment X)

f. Annual Reports:

   The Contractor shall provide an annual Operations report that contains a compilation and analysis of all reporting data and summarizes accomplishments, challenges and planned initiatives for the upcoming contract year.

4.3 Timeline of Reports

Weekly reports are due to the Department by close of business the first business day of the following week. Monthly reports are due by the 15th of the following month. Examples of monthly reports are provided in attachment XX. Cumulative quarterly reports are included in the monthly as a separate report. Annual reports are due within the last month of the quarter following the end of the fiscal year which is consistent with current contract and other reporting timelines. Reports are to be written and made available in Microsoft Word, PDF or Excel if applicable and be easily printable on 8 1/2' by 11" inch paper. The Contractor shall complete separate reports for the MEDALLION 3.0 Program and the CCC program.

4.4 Reports, Required Data and Schedule of Delivery:

- **Complaint Data**: Includes reporting of complaints in Medicaid program, and all of the following data elements: MCO/MMP Name or FFS, type of complaint, major category, sub-category, resolution, any information about an appeal, if available, and other criteria established by the Department. The Contractor is responsible for notifying the Department of any complaint that requires the immediate attention of the Department, as frequently as needed, via phone, email or weekly complaint log (weekly/monthly). The six (6) major categories of complaints for tracking purposes should include but are not limited to:

  - Transportation
  - Access to Health Services/Providers
  - Provider Care and Treatment
  - MCO/MMP customer service
  - Member payment/billing issues
  - Provider Reimbursement and Payment issues

  (Sub-categories shall be provided for each major category)

- **Conflict of Interest/Ownership Reporting:** Annual report indicating Freedom from conflict of interest and ownership/control information in accordance with requirements described in Section 3.1, and Attachment X of this RFP.
- **Plan Change Data:** reports Medicaid individual changes from one MCO/MMP to another. Includes the FIPS/Region, the MCO/MMP name, MCO/MMP name transferred to, reason for MCO/MMP change, reason description and total number of Medicaid individuals by MCO/MMP who changed for that month. (monthly).
- **DSS Address Discrepancy Notification Report:** Includes discrepancies found in Medicaid individual information that requires further research and correcting. This may include, but is not limited to, Medicaid individual's name, address, date of birth, social security number (weekly). This report should also be sent via email to designated contact in Systems and Reporting area within Health Care Services Division.
- **Enrollment Activity Report:** includes, at a minimum, completed enrollments per MCO/MMP. (monthly) Refer to Attachment XIII for more details.
- **Exclusion Data**: records Medicaid individual exemptions and the reasons for exemptions in accordance with DMAS guidelines. (weekly/monthly)

- **Fulfillment Packets**: Number of requests for information (MCO/MMP brochure/comparison chart) and the distribution by region locality. (monthly)
- **Health Status Assessment Report**: By MCO, includes the total number of Medicaid individuals who received an assessment by MCO and the date; weekly HSA reports posted to secure FTP site for MCO to retrieve. (weekly, monthly)
- **Summary Update Letter:** Summarizes, at a minimum, standards and actual results, call statistics for the week or month, customer service and enrollment activities performed by the HelpLine and any explanation to support discrepancies, etc. (weekly, monthly)
- **Helpline Activity Summary Report:** Summarizes, at a minimum, (and separately by program) the number of incoming calls, the number of answered calls, the average call wait time, the average talk time, the number of calls answered within three (3) minutes, the number and percentage of calls placed on hold and the average hold time, the number and percentage of abandoned calls, the average length of time until calls are abandoned, the number of calls in the queue at peak times and wait times for calls in the queue, the number of outbound calls and daily number of agents available (including overflow call center agent total). (weekly, quarterly, monthly) Refer to Attachment IV.
- **Monthly HelpLine Activity Report:** includes, at a minimum, total types of calls logged into database; i.e.: address changes, complaints, enrollment, exemption requests, good cause, provider, fulfillment, eligibility, etc. and total calls and percentage for each category (monthly).
- **Language Line:** reports the different languages provided by the service, the number of calls - associated with each language, the total incoming calls, percentage of incoming calls requiring language line assistance, overall and per language (monthly).
- **Managed Care Website Monthly Activity**: Provides daily, weekly and monthly number of visits and page views for the month, with report/graph on peak day of the month with a comparison to prior months. Also include number of website emails and turnaround time. Year-to-date data to include busiest day, average visits per day and length of visit and month to month comparison data (monthly).
- **Organizational Chart:** Provides functional units and names of key personnel(annually and when key personnel change
- **Medicaid individual Updated Phone Number List**: Create a Medicaid individual phone number listing using the Contractor's Medicaid individual database, by MCO health plan, that lists the Medicaid individual ID and phone number. Phone number updates will be shared by the Contractor with the MCOs weekly via secure FTP server process; MCO will log into secure Contractor FTP/Exchange server and pull report. (weekly) Report will be sent to DMAS on a monthly basis (monthly)
- **Customer Service Satisfaction Survey:** Create survey questions that measure responsiveness, knowledge, timeliness, politeness and overall quality of service for both the call center and the web-based enrollment process. The survey shall be added to the existing call script and results shall be reported that include overall satisfaction percentages, number of caller participants and comparison with prior months. The customer satisfaction survey shall also be implemented on the web-based enrollment portal. Survey questions shall be submitted to the Department for review and approval. The Contractor shall minimally sample a statistically relevant number of calls received on a monthly basis in order to obtain a minimal response rate of 10% of callers. An aggregate 90% satisfaction rate shall be maintained for each domain measured on a monthly basis. If this satisfaction rate is not achieved, the contractor shall submit a corrective action plan to DMAS with clear objectives with a timeline for meeting the aggregate satisfaction rate.

The Technical Proposal shall include a copy of a Customer Service Satisfaction Survey and survey results for a contract of similar size and scope to the contract described in this RFP for the two months immediately preceding the RFP issue date.

- **Program Integrity:** Provide summary of all designated fraud and abuse complaints, activities and results. (weekly/annually)

4.5 Risk Management and Security

The Contractor, at a minimum shall comply with VITA standards, which may be found on the VITA website at http://www.vita.virginia.gov. DMAS requires the Contractor to conduct a security risk analysis and to communicate the results in a Risk Management and Security Plan that will document Contractor's compliance with the most stringent requirements listed below:

- Section 1902 (a) (7) of the Social Security Act (SSA);
- 45 CFR Parts 160, and 164 Modifications to the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules Under the Health Information Technology for Economic and Clinical Health Act (HITECH) and the Genetic Information Nondiscrimination Act (GINA); Other Modifications to the HIPAA Rules; Final, January 25, 2013
- COV ITRM Policy SEC519-00 (latest version);
- COV ITRM Standard SEC501-07 (latest version).

At a minimum the following specific security measures shall be included in the Risk Management and Security Plan

- Computer hardware controls that ensure acceptance of data from authorized networks only;
- At the Contractor's central facility, placement of software controls that establish separate files for lists of authorized user access and identification codes;
- Manual procedures that provide secure access to the system with minimal risk.
- Multilevel, complex passwords, identification codes or other security procedures that must be used by state agency or Contractor personnel;
- All Contractor database software changes may be subject to the Department's approval prior to implementation; and
- System operation functions must be segregated from systems development duties.

If requested, the Contractor agrees that the Plan will be made available to appropriate state and federal agencies as deemed necessary by DMAS. If any changes occur during the contract period, the Contractor shall notify the contract monitor at the Department within 30 days prior to the change occurring.

4.6 Disaster Preparedness and Recovery at the Processing Site

The Contractor shall have a Business Continuity/Disaster Recovery Plan for its processing system prior to implementation. If requested, test results of the plan must be made available to the Department. The plan must be tested before the effective date of the contract and must meet the requirements of the Department and of any applicable state and federal regulations. The Contractor's Business Continuity/Disaster Recovery Plan must include sufficient information to show that it meets the following requirements: will comply with the following guidelines and standards:

- VITA website at the following link: http://www.vita.virginia.gov/library/default.aspx?id=537#securityPSGs and the VITA templates for IT Contingency Planning IT Contingency Planning Guideline (SEC508-00) (4/18/07 or later)
- National Institute of Standards and Technology (NIST) website at http://csrc.nist.gov/publications/nistpubs/800-34-rev1/sp800-34-rev1_errata-Nov11-2010.pdf NIST SP 800-34 Rev 1, May 2010, Contingency Planning Guide for Federal Information Systems (Appendix A System Templates for Moderate or High Impact Systems) and
- National Institute of Standards and Technology (NIST) website at http://csrc.nist.gov/publications/nistpubs/800-66-Rev1/SP-800-66-Revision1.pdf NIST SP 800-66 R1, October 2008, An Introductory Resource Guide for Implementing the Health Insurance Portability and Accountability Act (HIPAA) Security Rule and the following requirements of the HIPAA Security Rule Standards and Implementation specifications:
    1. Contingency Plan 45 CFR § 164.308(a)(7)(i)
    2. Data Backup Plan 45 CFR § 164.308(a)(7)(ii)(A)
    3. Disaster Recovery Plan 45 CFR§ 164.308(a)(7)(ii)(B)
    4. Emergency Mode Operation Plan 45 CFR § 164.308(a)(7)(ii)(C)
    2. Testing and Revision Procedures 45 CFR § 164.308(a)(7)(ii)(D)
    3. Applications and Data Criticality Analysis § 164.308(a)(7)(ii)(E)
    4. Facility Access Controls 45 CFR § 164.310(a)(1)
    5. Contingency Operations 45 CFR § 164.310(a)(2)(i)
    6. Device and Media Controls 45 CFR § 164.310(d)(1)
    7. Data Backup and Storage 45 CFR § 164.310(d)(2)(iv)
    8. Access Control 45 CFR § 164.312(a)(1)
    9. Emergency Access Procedure 45 CFR §164.312(a)(2)(ii)

At a minimum, the following specific security measures shall be included in the Business Continuity/Disaster Recovery Plan:

- Documentation of emergency procedures that include the steps to take in the event of a natural disaster by fire, water damage, sabotage, mob action, bomb threats, etc. This documentation will include the capability to continue receiving calls, and other functions required in this RFP in the event that the central site is rendered inoperable. Additionally, the Contractor's business continuity/disaster recovery plan must include provisions in relation to the processing center telephone number(s);
- Employees at the site must be familiar with the emergency procedures;
- Smoking must be prohibited at the site;
- Heat and smoke detectors must be installed at the site both in the ceiling and under raised floors (if applicable). These devices must alert the local fire department as well as internal personnel;
- Portable fire extinguishers must be located in strategic and accessible areas of the site. They must be vividly marked and periodically tested;
- The site must be protected by an automatic fire suppression system;
- The site must be backed up by an uninterruptible power source system; and
- The system at the disaster recovery site must be tested and verified in accordance with VITA standards.

The Business Continuity/Disaster Recovery Plan document will be available to the Department upon request during implementation and at least 30 days prior to beginning operations. If any changes occur during the contract period, the Contractor shall notify the Department's contract monitor within 30 days prior to the change occurring.

4.7 Continuity of Operations

The Contractor shall be required to provide written assurances that they have a Continuity of Operations (COOP) Plan that relates to the services or functions provided by them under this contract. Key information to be included in the Contractor's COOP and used as an example can be found on the VITA website at http://www.vita.virginia.gov/library/default.aspx?id=537#securityPSGs for templates for Virginia Department of Emergency Management (VDEM) Continuity documents:

VDEM Continuity Plan Template
VDEM Guide to Identifying Mission Essential Functions and
Mission Essential Function Identification Worksheets

If requested, the Continuity of Operations Plan document shall be available to the Department during implementation and at least 30 days prior to beginning operations. If any changes occur during the contract period, the Contractor shall notify the contract monitor at the Department within 30 days after the change occurred.

4.8 Security Training

The Contractor shall be required to provide written assurances that they have a Security Training Plan that relates to the services or functions provided by them under this contract. If requested the Security Training Plan document shall be available to the Department during implementation and at least 30 days prior to beginning operations. If any changes occur during the contract period, the Contractor shall notify the contract monitor at the Department within 30 days prior to change occurring.

5. DEPARTMENT RESPONSIBILITIES

The Department shall provide a designated Contract Administrator to maintain communication with the Contractor. The Department shall meet with the Contractor's representative on a bi-monthly basis and communicate daily (if needed) to discuss the Enrollment Broker activities and manage the day-to-day activities. During such, issues such as enrollment questions, VaMMIS system problems, project plan and education plans, processes, etc. will be addressed.

The functions and duties of the Department shall include:

1. Final authority and responsibility for excluding individuals from the managed care program.
2. Establish guidelines for electronically entering managed care Medicaid individual data into the VaMMIS,
3. Provide, through its contracted mailing vendor, copies of letters for informational purposes to be mailed to managed care eligible Medicaid individuals, including monthly, open enrollment, etc.

4. Work with the Contractor and MCO/MMPs to facilitate the process of establishing an FTP site to facilitate the exchange of information to and from the MCO/MMPs to include provider data files, completed HSAs, etc.
5. Provide the Contractor the enrollment cut-off date (MMIS schedule) six months in advance or as soon as the information is available to the Department.
6. Assist the Contractor in acquiring access to VaMMIS on weekends and holidays, as needed.
7. Approve print materials i.e. comparison charts, policy, procedural and training manuals, scripts, after hours messages (as applicable), website updates, etc.
8. Provide in-service training to the Contractor staff, as necessary, for implementation of the contract and shall notify the Contractor of on-going program changes affecting the contract.
9. Perform monitoring activities to assess the extent to which the Contractor meets contract performance standards and requirements; and adheres to the policies, procedures and regulations of the Department by conducting reviews of the Contractor's operations at any time, including but not limited to call center operations, Managed Care Helpline activity, Automated Call Distributor reports, system's functions and activities.
10. Assist in the resolution of problems issues and complaints determined to not be within the Contractor's ability to resolve as agreed upon by the Department and the Contractor.
11. Have five regional annual open enrollment periods where managed care Medicaid individuals can change MCO/MMPs without cause.
12. Approve the Contractor's reporting format and reserves the right to change reporting requirements as needed and to request ad hoc reports if needed.
13. Notify the Contractor of contract non-compliance with contract requirements and review Contractor corrective actions for resolution.
14. The Department, through its Fiscal Agent, shall provide the Contractor a monthly extract of case and Medicaid individual eligibility data.
15. Provide feedback to Contractor after testing Call Center access and functionality and monitoring call quality.
16. Provide weekly materials inventory sheet from the contractor responsible for enrollment broker services for the FAMIS program, listing usage, number of charts ordered, etc.

6. PAYMENTS TO THE CONTRACTOR

The Contractor will be compensated monthly based on the negotiated fixed, unit price per call, for each call Tier, multiplied by the actual monthly call volume for Medallion 3.0 and CCC. The tiered unit price per call is not cumulative, meaning that the Department will only pay one price for all calls in each member program, i.e. one price for Medallion 3.0 and one price for CCC, within the calendar month.

CCC reimbursable costs are through December 31, 2017, the end of the demonstration. Funding for an additional contract year through December 31, 2018, the end of the contract base period, is subject to approval by the Centers for Medicare and Medicaid Services. If approved, the Department may exercise a contract modification for continuation of CCC services.

Payments to the Contractor shall also be subject to the General Terms and Conditions and the Special Terms and Conditions in Sections 9 and 10, of this RFP.

6.1 Travel Compensation

The Contractor will not be compensated or reimbursed for travel, meals, or lodging.

6.2 Payment of Invoice

6.2.1 Start-up/Implementation

The Start-up and Implementation period begins the date of contract execution to the date of the start of operations. Costs will be reimbursed 30 calendar days after successful implementation as determined by DMAS.

6.2.2 Operations

The Contractor will be paid monthly based on a complete and accurate monthly invoice(s) submitted by the last day of each month for services provided in the preceding month, beginning with the 1st month of implementation. The Contractor shall submit separate monthly invoices unique to Medallion 3.0 and the Commonwealth Coordinated Care Program. The invoices should be sent to BCMinvoices@dmas.virginia.gov.

The payment of invoices, by the Department, shall not prejudice the Department's right to object to or question any invoice or matter in relation thereto. Such payment by the Department shall neither be construed as acceptance of any part of the work or service provided nor as an approval of any of the amounts invoiced therein.

6.3 Payment Reductions

The Contractor's invoice shall be subject to reduction for amounts included in any invoice or payment that are determined by the Department not to constitute proper remuneration for compensable services on the basis of audits conducted in accordance with the terms of this RFP.

6.4 Payment Deductions

The Department reserves the right to deduct from amounts which are or shall become due and payable to the Contractor under this or any contract between the Contractor and the Commonwealth of Virginia any amounts which are or shall become due and payable to the Commonwealth of Virginia by the Contractor, as described in in Attachment XIX of this RFP.

6.5 Payment Modifications

The Department will issue payments at the rate(s) established in this Contract, subject to any programmatic or budgetary changes that may result from legislative or Agency action.

DMAS will notify the Contractor of any additions or deletions of programs and/or populations and its projected impact on payment as soon as the Department has sufficient information to determine it has an impact on the Contractor.

6.6 Annual Review of Internal Controls

The Contractor shall provide the Department, at a minimum, a report from its external auditor on effectiveness of internal controls. If the report discloses, deficiencies in internal controls, the Contractor shall include management's corrective action plans to remediate the deficiency. If available, report shall be compliant with the AICPA Statement on Standards for Attestation Engagements (SSAE) No 16, Reporting on Controls at a Service Organization, Service Organizations Controls (SOC) 2, Type 2 Report, and include the Contractor and its third-party service providers. The internal control reports shall be provided annually each June 1st for the preceding calendar year.

7. PROPOSAL PREPARATION AND SUBMISSION REQUIREMENTS

This RFP is issued by the Department. The Department will be the sole point of contact with all interested Offerors from the date of release of the RFP until the contract is fully executed and signed. Offerors should not contact any state employees other than the individuals indicated in this RFP.

If it becomes necessary to revise any part of this RFP, or if additional data are necessary for an interpretation of provisions of this RFP prior to the due date for proposals an addendum will be issued. Offerors must check eVA VBO at http://www.eva.virginia.gov for all official addenda or notices regarding this RFP. While DMAS also intends to post such notices on the DMAS website at http://www.dmas.virginia.gov/Content_pgs/rfp.aspx, eVA is the official and controlling posting site. If supplemental releases are necessary, the Department reserves the right to extend the due dates and time for receipt of proposals to accommodate such interpretations of additional data requirements.

Each Offeror responding to this proposal shall submit a separate Technical Proposal and a Cost Proposal in relation to the requirements described in this RFP. The following describes the general requirements and the specific requirements for the Technical Proposal and the cost proposal.

7.1 Overview

Both the Technical Proposal and the Cost Proposal shall be developed and submitted in accordance with the instructions outlined in this section. The Offeror's proposals shall be prepared simply and economically, and they shall include a straightforward, concise description of the Offeror's capabilities that satisfy the requirements of the RFP. Although concise, the proposals should be thorough and detailed so that the Department may properly evaluate the Enrollment Broker's capacity to provide the required services. All descriptions of services should include an explanation of proposed methodology, where applicable. The proposals may include additional information that the Offeror considers relevant to this RFP.

The proposals should be organized in the order specified in this RFP. A proposal that is not organized in this manner risks a lower score or elimination from consideration if the evaluators are unable to find where the RFP requirements are specifically addressed. The Department and the evaluators are not obligated to ask an Offeror to identify where an RFP requirement is addressed, and no Offeror should assume that it will have an opportunity to supplement its proposal or to assist the evaluators in understanding and evaluating its proposal.

7.2 Critical Elements of the Technical Proposal

The Offeror must cross reference its Technical proposal with each requirement listed in this RFP in Sections 3 and 4. In addition, the Offeror must ensure that the following documentation is included in the proposal.

Enrollment Broker Qualifications: The proposal must include a summary of the Offeror's qualifications. Documentation of directly related experience and credentials is necessary. Special emphasis will be placed upon experience in performing similar services for state or federal government human services organizations.

The Offeror must describe its experience, including length of time, working in the health care industry with particular focus on managed care, enrollment activities experience and the Medicaid population. The response should include descriptions of current and previous contractual agreements, responsibilities, time periods, work performed, volume handled and enrollment processes currently used. The Offeror must also:

- Demonstrate its experience in Medicaid customer service and community outreach in the health care industry, including special needs populations.
- Describe its experience in the areas of marketing and public relations or the experience of any sub-Contractors it will employ.
- Describe its experience in operating a toll-free information line, including a description of the purpose of the toll free number, types of calls received, volume of calls, and telecommunications system used.
- Include a summary of technical and delivery systems used or interfaced in the above projects.
- Describe the Offeror's previous experience in services and operational functions in similar contracts.
- Describe previous experience in providing specialized education and enrollment processes with itemized services for Acute and Long-Term Care population in a state organization.
- Describe prior experience and technological capabilities for operation of a comprehensive, state of the art call center, capable of responding to Medicaid individual concerns; providing Medicaid individual education; and handling enrollment activity for Medicaid individuals with complex health care needs.
- Describe previous experience in the development, implementation, and maintenance of a website including the features required in this RFP.

Implementation Plan: The Offeror shall submit a detailed implementation plan demonstrating the Contractor's proposed schedule to fully implement Enrollment Broker Services within 5 business days of contract award. The implementation plan shall be prepared in Microsoft MS Project, delineate each deliverable, task, and subtask with milestones and dates through the end of the first contract year and include a dedicated project manager. A comprehensive report on the status of each task, subtask, and deliverable shall be provided, to the Department by the Contractor, every week from the time of contract execution through three months after successful implementation. The Contractor and Department will work together during initial contract start-up to establish a schedule for key activities

and define expectations for the content and format of contract deliverables through the first Fiscal Year.

The Department may make such reasonable investigations as deemed proper and necessary to determine the ability of the Contractor to perform the services and the Contractor Shall furnish to the Department all such information and data for this purpose within requested timeframes. The Department reserves the right to inspect Contractor's physical facilities, including any located outside of Richmond, Virginia any time prior to award and anytime during the contract period to satisfy questions regarding the Contractor's capabilities. The Department further reserves the right to reject any proposal if the evidence submitted by, or investigations of, the Contractor fails to satisfy the Department that the Contractor is properly qualified to carry out the obligations of the contract and to provide the required services.

Enrollment Process: Submit a detailed description of the manner in which it proposes to perform the responsibilities detailed in Section 3 of this RFP. The plan must include a step by step description of the procedures by which a Medicaid individual is assisted in selecting the health plan of their choice.

Help Line Operations: Submit a detailed description of how it will properly staff and operate a toll-free Help Line(s), and how individuals will be identified by program including process for routine and emergency calls and including how Medicaid individuals will be triaged to other appropriate resources. The plan must describe the information and assistance that will be provided by Representatives CSRs to Medicaid individuals.

Telecommunications System: Submit a description of a proposed system which meets the requirements of Section 3.

Staffing: The Offeror must submit a detailed description of the staffing plan, which describes the types of personnel who shall be hired to become Representatives, how staff shall be compensated (hourly, wage, temporary), and how the staff shall be supervised. This section shall also include a description of the Offeror's plan for staff training, including components and length of training curriculum, a plan for on-going training, and a proposal of a Training Guide and a Policies and Procedures Manual.

Auditing: Submit a description of how all enrollment and education-related activities shall be audited by the Offeror, including the requirement that assistance in health plan selection be completely objective, and that Help Line responses are accurate. This section must also describe a plan to ensure confidentiality of Medicaid individual's records. Provide a copy of daily standard audit form used on internal staff to measure production scores by Offeror.

Miscellaneous: The Offeror must submit the following in response to this RFP:

- A proposed Heath Status Assessment tool and a description of how it will be administered
- Sample of weekly/monthly/annual reports
- Sample of Medicaid individual enrollment materials such as MCO/MMP brochure and MCO/MMP comparison chart
- Statement attesting freedom from conflict of interest per 3.1 and Attachment X.

Capacity Summary: The proposal must include a capacity summary (physical plant, equipment, and critical personnel) including a discussion of the Offeror's capacity to successfully provide the desired services in light of other potential and known demands upon those resources.

Summary of Key Staff: The proposal must include a staff summary and identification of key staff, to include a qualified project director/manager who will be working on the project, and their relevant experience. Professional resumes/and or detailed job descriptions for staff must be included with an indication of their area(s) of expertise (e.g. enrollment, call center, etc.).

References: The proposal must include a minimum of three non-Offeror owned customer references utilizing the reference form included as Attachment I. In addition, the proposal must include a list of all state governments, Medicaid business in particular, for which the Offeror is currently under contract with for similar services outlined in this RFP. The Offeror shall also include all Enrollment Broker contracts, both Medicaid and non-Medicaid, held by the Offeror anytime since 12/01/2010.

Small Business Subcontracting Plan: The Offeror shall be required to submit a report on the planned utilization of Department of Small Business and Supplier Diversity (DSBSD) certified small businesses and small businesses owned by women and minorities under the contract to be awarded as a result of this solicitation. (Attachment II). Names of Virginia certified firms may be available from the Department of Small Business and Supplier Diversity at http://www.sbsd.virginia.gov Offerors shall submit their Small Business Subcontracting Plans with their Cost Proposal submission.

Organizational Structure: The Offeror must state its name, address, and telephone number, and provide:

- An organizational chart depicting the Offeror's organization in relation to any parent, subsidiary, and related organization.
- Significant subcontracts and assignment relationships.
- The names and occupations of the Medicaid individuals of the Board of Directors of the organization(s).

Offeror's Financial Stability: The Offeror shall submit evidence of financial stability. The Offeror shall submit one of the following financial reports (a or b):

a. For a publicly held corporation, a copy of the most recent 3 years of audited financial reports and financial statements; or

b. For a privately held corporation, sole proprietorship, limited liability company, partnership, or other organization or entity, financial information for the past 3 years, similar to that included in an annual report, to include at a minimum, an income statement; a statement of cash flows; a balance sheet; number of years in business; and telephone number of a contact in the Offeror's principal financial or banking organization and its auditor.

Systems Interface Plan: This section shall describe the Offeror's existing computer capabilities and proposed enhancements or new capabilities specifically intended for this contract. This section should

include a description of those functions that will be automated and a description of the hardware and software to be used. The hardware description should include the brand and model of the platform planned for the contract, the operating system and available peripherals. The software description should include a schematic overview of the system, volume capacities, file layouts, edits, language in which the software is written, and an estimate of the level of effort and time frames to modify the software for the purposes of this contract. The software description should also include the proposed methodology to interface with the VaMMIS and accept data from participating health plans.

7.3 Cost Proposal

Required Services

The Offeror shall submit one cost proposal for required services that includes segregated costs for Medallion 3.0 and Commonwealth Coordinated Care (CCC) using the format provided in Attachment III Cost Proposal. The cost proposal shall include separate Start-up and Implementation costs for Medallion 3.0 and CCC. The Start-up and Implementation period begins the date of contract execution to the date of the start of operations. The cost proposal shall also include separate annual operations budgets for Medallion 3.0 and CCC.

Optional Services

The Offeror shall also submit one cost proposal for the CCC Mandatory Program and one cost proposal for Managed Long-Term Services and Supports (MLTSS).

The cost proposals for Optional Services will not be included in the scoring of the proposals or evaluation process.

The Cost Proposal (1 copy) shall be sealed separately from the Technical Proposal, and labeled "Cost Proposal." The Offeror shall submit costs using the format provided in Attachment III.

No cost information is to be included in any portion of the technical proposal.

Administrative costs services shall **not** include:

- Related party management fees in excess of actual cost
- Lobbying expenses
- Contributions
- State and federal income taxes
- Administrative fees for services provided by a parent organization, which did not represent a pass through of actual costs
- Management fees relating to non-Virginia operations or operations in Virginia for other contracts
- Management fees paid for the sole purpose of securing an exclusive arrangement for the provision of services for specific Medicaid Individuals

- Administrative fee/royalty licensing agreements for services provided by a parent organization, which did not represent a pass through of actual costs
- Accruals for future losses
- Reserves based on estimates for bankrupt providers
- Unsupported expenses
- Expenses related to the preparation of the proposal.

7.4 Binding of Proposal

The Technical Proposal shall be clearly labeled "RFP 2015-01Technical Proposal" on the front cover. The Cost Proposal shall be clearly labeled "RFP 2015-01 Cost Proposal" on the front cover. The legal name of the organization submitting the proposal shall also appear on the covers of both the Technical Proposal and the Cost Proposal.

The proposals shall be typed, bound, page-numbered and single-spaced with a 12-point font on 8 1/2" x 11" paper with 1" margins and printed on one side only. Offerors may use a larger size font for section headings and may use a smaller font size for footers, tables, graphics, exhibits, or similar sections, if necessary. Larger graphics, exhibits, organization charts, and network diagrams may also be printed on larger paper as a foldout if 8 ½" x 11" paper is not practical. Each hard copy of the Technical Proposal and each hard copy of the Cost Proposal and all documentation submitted shall be contained in single three-ring binder volumes where practical. A tab sheet keyed to the Table of Contents shall separate each major section. The title of each major section shall appear on the tab sheet.

The Offeror shall submit an original and four (4) copies of the Technical Proposal and one original of the Cost Proposal by the response date and time specified in this RFP. Each copy of the proposal shall be bound separately. This submission shall be in a sealed envelope or sealed box clearly marked "RFP 2015-01Technical Proposal". In addition, the original of the Cost Proposal shall be sealed separately and clearly marked "RFP 2015-01 Cost Proposal" and submitted by the response date and time specified in this RFP. The Cost Proposal forms in Attachment III shall be used. The Offeror shall also submit one electronic copy (compact disc preferred) of their Technical Proposal in MS Word format (Microsoft Word 2007 or compatible format) and of their Cost Proposal in MS Excel or Word format (Microsoft Word 2007 or compatible format). In addition, the Offeror shall submit a redacted (proprietary and confidential information removed) electronic copy in PDF format of their Technical Proposal and Cost Proposal, in which the Offeror has removed proprietary and confidential information. Please note that, as described below, merely redacting information is not sufficient to comply with Code of Virginia § 2.2-4342(F).

7.5 Table of Contents

The proposal shall contain a Table of Contents that cross-references the RFP submittal requirements in Section 3 and 4. Each section of the Technical Proposal shall be cross-referenced to the appropriate section of the RFP that is being addressed. This will assist the Department in determining uniform compliance with specific RFP requirements.

7.6 Submission Requirements

All information requested in this RFP shall be submitted in the Offeror's proposals. A Technical Proposal shall be submitted and a Cost Proposal shall be submitted in the Offeror's collective response. The proposals will be evaluated separately. By submitting a proposal in response to this RFP, the Offeror certifies that all of the information provided is true and accurate.

All data, materials and documentation originated and prepared for the Commonwealth pursuant to this RFP belong exclusively to the Commonwealth and shall be subject to public inspection in accordance with the Virginia Freedom of Information Act and subject to Code of Virginia § 2.2-4342. Trade secrets or proprietary information shall be clearly marked in the proposal and reasons why the information should be confidential shall be clearly stated.

Trade secrets or proprietary information submitted by an Offeror are not subject to public disclosure under the Virginia Freedom of Information Act; however, the Offeror shall invoke the protections of § 2.2-4342(F) of the Code of Virginia, in writing, either before or at the time the data is submitted. The written notice shall specifically identify the data or materials to be protected and state the reasons why protection is necessary.

The proprietary or trade secret materials submitted shall be identified by some distinct method, such as highlighting or underlining, and shall indicate only the specific words, figures, or paragraphs that constitute trade secret or proprietary information. The electronic redacted copy of the technical proposal and cost proposal shall have the proprietary and trade secret information removed or blocked out in its entirety so the content is not visible. The classification of an entire proposal document, line item prices and/or total proposal prices as proprietary or trade secrets is not acceptable and, in the sole discretion of DMAS, may result in rejection and return of the proposal**. Attachment XXIII of this RFP shall be used for the identification of proprietary or trade secret information and submitted with the technical proposal**.

All information requested by this RFP on ownership, utilization and planned involvement of small businesses, small women-owned businesses and small minority-owned business (**Attachment II) shall be submitted with the Offeror's Cost Proposal.**

7.7 Transmittal Letter

The transmittal letter shall be on official organization letterhead and signed by the individual authorized to legally bind the Offeror to contract agreements and the terms and conditions contained in this RFP. The organization official who signs the proposal transmittal letter shall be the same person who signs the cover page of the RFP and Addenda (if issued).

At a minimum, the transmittal letter shall contain the following:

1. A Statement that the Offeror meets the required conditions to be an eligible candidate for the contract award including:
   a) The Offeror and any related entities must identify any client relationships, contracts or agreements they have with any state or local government entity that is a Medicaid and/or

FAMIS facility or Contractor and the general circumstances of the contract or agreement. This information will be reviewed by the Department to ensure there are no potential conflicts of interest;

b) Offeror must be able to present sufficient assurances to the state that the award of the contract to the Offeror shall not create a conflict of interest between the Contractor, the Department, and its subcontractors; and

c) The Offeror must be licensed to conduct business in the state of Virginia.

2. A Statement that the Offeror has read, understands and agrees to perform all of the Contractor responsibilities and comply with all of the requirements and terms set forth in this RFP, any modifications of this RFP, the Contract and Addenda;
3. The Offeror's general information, including the address, telephone number, and facsimile transmission number;
4. Designation of an individual, to include their e-mail and telephone number, as the authorized representative of the organization who will interact with the Department on any matters pertaining to this RFP and the resultant Contract; and
5. A Statement agreeing that the Offeror's proposal shall be valid for a minimum of 180 days from its submission to the Department.

7.8 Signed Cover Page of the RFP and Addenda

To attest to all RFP terms and conditions, the authorized representative of the Offeror shall sign the cover page of this RFP, as well as the cover page of the Addenda (if issued), to the RFP; the Certification of Compliance with Prohibition of Political Contributions and Gifts during the Procurement Process" form (**Attachment XXII)** and The State Corporate Commission form **(Attachment XXIV)** and submit them along with the Technical Proposal.

7.9 Procurement Contact

The principal point of contact for this procurement in the Department shall be:

Scott Cannady, Contract Administrator
Managed Care Division
Virginia Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, VA 23219
E-mail RFP2015-01@dmas.virginia.gov

All communications with the Department regarding this RFP should be directed to the principal point of contact or the DMAS Contract Management Officer named in the cover memo. All RFP content-related questions shall be in writing to the principal point of contact. An Offeror who communicates with any other employees or Contractors of the Department concerning this RFP after issuance of the RFP may be disqualified from this procurement.

7.10 Submission and Acceptance of Proposals

The proposals, whether mailed or hand delivered, shall arrive at the Department no later than 10:00 a.m. E.S.T. on August 17, 2015. The Department shall be the sole determining party in establishing the time of arrival of proposals. Late proposals shall not be accepted and will be automatically rejected from further consideration. The address for delivery is:

Proposals may be sent by US mail, Federal Express, UPS, etc. to:
Attention: Christopher Banaszak
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, VA 23219

Hand Delivery or Courier to:
Attention: Christopher Banaszak
Department of Medical Assistance Services
7th Floor DMAS Receptionist
600 East Broad Street
Richmond, VA 23219

DMAS reserves the right to reject any or all proposals. Reference Code of Virginia § 2.2-4319. DMAS reserves the right to delay implementation of the RFP if a satisfactory Contractor is not identified or if DMAS determines a delay is necessary to ensure implementation goes smoothly without service interruption. Offerors must check the eVA VBO at http://www.eva.virginia.gov for all official postings of addendums or notices regarding this RFP. DMAS also intends to post such notices on the DMAS website at http://www.dmas.virginia.gov/Content_pgs/rfp.aspx but the eVA VBO is the official posting site that Offerors must monitor.

7.11 Oral Presentation and Site Visit

At any point in the evaluation process, DMAS may employ any or all of the following means of evaluation:

- Reviewing Industry Research
- Offeror Presentations
- Site Visits
- Contacting Offerors References
- Product Demonstrations/Pilot Tests
- Obtain a Dun and Bradstreet Report on the Offeror
- Obtain a Securities Exchange Commission Report on the Offeror
- Requesting Offeror elaborate on or clarify specific portions of their proposals.

No Offeror is guaranteed an opportunity to explain, supplement or amend its initial proposal. Offerors must not submit a proposal assuming that there will be an opportunity to negotiate, amend or clarify any aspect of their submitted proposals. Therefore, each Offeror is encouraged to ensure that its initial proposal contains and represents its best offer.

Offerors should be prepared to conduct product demonstrations, pilot tests, presentations or site visits at the time, date and location of DMAS' choice, should DMAS so request.

DMAS may make one or more on-site visits to see the Offeror's operation of another contract. DMAS shall be solely responsible for its own expenses for travel, food and lodging.

7.12 RFP Schedule of Events

The following RFP Schedule of Events represents the state's proposed timeframe that will be followed for implementation of the program.

EVENT	DATE
State Issues RFP	July 1, 2015
Letter of Intent	July 13, 2015
Deadline for Written Questions and Comments	July 13, 2015
Deadline for Submitting a Proposal to the Department	August 17, 2015
Implementation Date	January 1, 2016

7.13 Supplemental Information

The following web links are provided for informational purposes and may be referenced at the Offeror's discretion. The following items are available on-line:

- Virginia Medical Assistance Provider Manuals
  https://www.virginiamedicaid.dmas.virginia.gov/wps/portal
- Virginia Administrative Code Title 12VAC30120 sections 270-420 (Medicaid program regulations)
  http://leg1.state.va.us/cgi-bin/legp504.exe?000+men+SRR
- General Information - Section 1915(b) Waiver
  http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html
- Title 42 CFR Section 438 (Managed Care)
  http://www.access.gpo.gov/nara/cfr/waisidx_07/42cfrv4_07.html
- MC Studies and Reports
  http://www.dmas.virginia.gov/Content_pgs/mc-home.aspx
- Medicaid Handbook
  http://www.dmas.virginia.gov/Content_atchs/atchs/medbook-eng.pdf
- MEDALLION 3.0 Contract
  http://www.dmas.virginia.gov/Content_pgs/mc-home.aspx
- FAMIS Website/Information
  http://www.coverva.org/
- HIPAA Final Rules and Standards
  http://aspe.hhs.gov/admnsimp/Index.htm

- Description of Home and Community-Based Waivers
  http://www.dmas.virginia.gov/Content_pgs/ltc-home.aspx
- Managed Care Website and Links to MCO websites
  www.virginiamanagedcare.com
- CCC Program Background Information and Documents
  www.dmas.virginia.gov/Content_pgs/valtc.aspx

8. PROPOSAL EVALUATIONS AND AWARD CRITERIA

DMAS will evaluate the Technical and Cost Proposals received in response to this RFP in a fair and impartial manner provided for by the Virginia Public Procurement Act (Va. Code § 2.2-4300, *et seq*.). The Evaluation Team will be responsible for the review and scoring of all Technical Proposals and the Office of Budget and Contract Management will review and score the Cost Proposals and Small Business Subcontracting Plans. This group will be responsible for making the final recommendation to award to the DMAS Director.

8.1 Evaluation of Minimum Requirements

The Department will initially determine if each proposal addresses the minimum RFP requirements to permit a complete evaluation of the Technical and Cost Proposals. Proposals shall comply with the instructions to Offerors contained throughout this RFP. Failure to comply with the instructions may result in a lower score or elimination from further consideration (reference Agency Procurement and Surplus Property Manual (APSPM) § 7.3(b)). DMAS reserves the right to waive minor irregularities.

The minimum requirements for a proposal to be given consideration are:

Signature Sheets: RFP Cover Sheet, Addenda (if issued), Transmittal Letter, Certification of Compliance with Prohibition of Political Contributions and Gifts During the Procurement Process (Attachment XXII), Proprietary/Confidential Information Identification Form (Attachment XXIII) and, State Corporation Commission Form (Attachment XXIV). These forms shall be completed and properly signed by the authorized representative of the organization

Closing Date: The proposal shall have been received, as provided in Section 7.10, before the closing of acceptance of proposals in the number of copies specified.

Mandatory Conditions: All mandatory General and Special Terms and Conditions contained in Sections 9 and 10 shall be accepted.

Small Business Subcontracting Plan: Summarize the planned utilization of Department of Small Business and Supplier Diversity (DSBSD)-certified small businesses under the contract to be awarded as a result of this solicitation. (Attachment II). **The Small Business Subcontracting Plan is a requirement for all prime contracts in excess of $100,000 unless no subcontracting opportunities exist and is a scored criterion and, if applicable, documents the Offeror and/or their planned subcontractors as a small business certified by the Department of Small Business and Supplier Diversity (DSBSD). Offerors are encouraged to populate the table with their plans to utilize small businesses from joint ventures, partnerships, suppliers, and etc. Regardless of planned Small Business utilization, all proposals must have this attachment included in their Cost Proposal.**

DSBSD is the only Virginia agency authorized to certify small businesses, and DMAS will not question, re-evaluate, investigate, or otherwise look behind DSBSD's certification decisions. DMAS will evaluate the Small Business Subcontracting Plan in accordance with APSPM §7.2(j) and solely by checking, through DSBSD's website, the certification status as of the due date for receipt of proposals. To receive the maximum score for the Small Business Subcontracting Plan criterion, the submitting Offeror must be a small business as certified by DSBSD.

8.2 Proposal Evaluation Criteria

The broad criteria for evaluating proposals include the elements below:

Criteria	Weights
1. Experience of the Offeror in Medicaid Enrollment Broker Services.	**20%**
a) Experience of the Offeror in working with indigent populations, particularly Medicaid or other healthcare populations, as well as experience in performing services within the past year(s) most comparable to the Offeror's proposal.	
2. Technical Proposal - Demonstration in the written proposal of the Offeror's ability, facilities and capacity to provide all required services in a timely, efficient and professional manner.	**25%**
a) Clarity and thoroughness of the Offeror's proposal in addressing the requirements of the RFP efficiently and effectively.	
b) Proposed project management of the resources available to the Offeror for meeting the requirements of the RFP.	
c) Work plan distribution of person hours for each Task.	
3. Staffing - Experience and expertise of specific staff assigned to the contract.	**15%**
a) Prior experience of staff with similar projects.	
b) Qualifications of staff.	
c) Appropriateness of the relationship between staff qualifications and assigned responsibilities.	
4. Quality of References	**5%**
a) References who substantiate the Offeror's qualifications and capabilities to perform the services required by the RFP.	
b) References who substantiate the quality of the work processes and outputs of the Offeror.	
5. Small Business Subcontracting Plan - Attachment II	**20%**
6. Cost Proposal	**15%**
a) The Cost Proposal shall be evaluated taking into consideration the costs shown in Attachment III "Cost Proposal."	

The cost proposal shall be evaluated and weighted but is not the sole deciding factor for the RFP. The lowest cost proposal shall be scored the maximum number of evaluation points for cost. All other cost proposals shall be evaluated and assigned points for cost in relation to the lowest cost proposal.

8.3 Signing and Execution of the Contract

The successful Offeror will be required to enter into a contract with the Department within seven (7) days of having received a Final contract document from the Department. If the Offeror fails to enter into a contract within seven (7) days, the state may withdraw the notice and select another Offeror, restart the procurement, or discontinue the procurement entirely.

9. GENERAL TERMS AND CONDITIONS

9.1 Vendors Manual

This solicitation is subject to the provisions of the Commonwealth of Virginia *Vendors Manual* and any changes or revisions thereto, which are hereby incorporated into this contract in their entirety. The procedure for filing contractual claims is in section 7.19 of the *Vendors Manual*. A copy of the manual is normally available for review at the purchasing office and is accessible on the Internet at www.eva.virginia.gov under "Vendors Manual" on the vendors tab.

9.2 Applicable Laws and Courts

This solicitation and any resulting contract shall be governed in all respects by the laws of the Commonwealth of Virginia and any litigation with respect thereto shall be brought in the courts of the Commonwealth. The Department and the Contractor are encouraged to resolve any issues in controversy arising from the award of the contract or any contractual dispute using Alternative Dispute Resolution (ADR) procedures (Code of Virginia, §2.2-4366). ADR procedures are described in Chapter 9 of the *Vendors Manual.* The Contractor shall comply with all applicable federal, State and local laws, rules and regulations.

9.3 Anti-Discrimination

By submitting their proposals, Offerors certify to the Commonwealth that they shall conform to the provisions of the Federal Civil Rights Act of 1964, as amended, as well as the Virginia Fair Employment Contracting Act of 1975, as amended, where applicable, the Virginians With Disabilities Act, the Americans With Disabilities Act and §2.2-4311 of the Virginia Public Procurement Act (VPPA), and any other applicable laws. If the award is made to a faith-based organization, the organization shall not discriminate against any Medicaid individual of goods, services, or disbursements made pursuant to the contract on the basis of the Medicaid individual's religion, religious belief, refusal to participate in a religious practice, or on the basis of race, age, color, gender or national origin and shall be subject to the same rules as other organizations that contract with public bodies to account for the use of the funds provided; however, if the faith-based organization segregates public funds into separate accounts, only the accounts and programs funded with public funds shall be subject to audit by the public body. (Code of Virginia, §2.2-4343.1E).

In every contract over $10,000, the provisions in Sections 9.3.1 and 9.3.2. below apply:

9.3.1. During the performance of this contract, the Contractor agrees as follows:

a) The Contractor shall not discriminate against any employee or applicant for employment because of race, religion, color, sex, national origin, age, disability, or any other basis prohibited by state law relating to discrimination in employment, except where there is a bona fide occupational qualification reasonably necessary to the normal operation of the Contractor. The Contractor agrees to post in conspicuous places, available to employees and applicants for employment, notices setting forth the provisions of this nondiscrimination clause.

b) The Contractor, in all solicitations or advertisements for employees placed by or on behalf of the Contractor, shall state that such Contractor is an equal opportunity employer.

c) Notices, advertisements and solicitations placed in accordance with federal law, rule or regulation shall be deemed sufficient for the purpose of meeting these requirements.

9.3.2. The Contractor shall include the provisions of 9.3.1 above in every subcontract or purchase order over $10,000, so that the provisions will be binding upon each subcontractor or Contractor.

9.4 Ethics in Public Contracting

By submitting their proposals, Offerors certify that their proposals are made without collusion or fraud and that they have not offered or received any kickbacks or inducements from any other Offeror, supplier, manufacturer or subcontractor in connection with their proposal, and that they have not conferred on any public employee having official responsibility for this procurement transaction any payment, loan, subscription, advance, deposit of money, services or anything of more than nominal value, present or promised, unless consideration of substantially equal or greater value was exchanged.

9.5 Immigration Reform and Control Act Of 1986

By entering into a written contract with the Commonwealth of Virginia, the Contractor certifies that the Contractor does not, and shall not during the performance of the contract for goods and services in the Commonwealth, knowingly employ an unauthorized alien as defined in the Federal Immigration Reform and Control Act of 1986.

9.6 Debarment Status

By participating in this procurement, the vendor certifies that they are not currently debarred by the Commonwealth of Virginia or any federal, state or local government from submitting a response for the type of goods and/or services covered by this solicitation,. Vendor further certifies that they are not debarred from filling any order or accepting any resulting order, or that they are an agent of any person or entity that is currently debarred by the Commonwealth of Virginia.

9.7 Antitrust

By entering into a contract, the Contractor conveys, sells, assigns, and transfers to the Commonwealth of Virginia all rights, title and interest in and to all causes of action it may now have or hereafter acquire under the antitrust laws of the United States and the Commonwealth of Virginia, relating to the particular goods or services purchased or acquired by the Commonwealth of Virginia under said contract.

9.8 Mandatory Use of State Form and Terms and Conditions

Failure to submit a proposal on the official state form, in this case the completed and signed RFP Cover Sheet, may be a cause for rejection of the proposal. Modification of or additions to the General Terms and Conditions of the solicitation may be cause for rejection of the proposal; however, the Commonwealth reserves the right to decide, on a case by case basis, in its sole discretion, whether to reject such a proposal.

9.9 Clarification of Terms

If any prospective Offeror has questions about the specifications or other solicitation documents, the prospective Offeror should contact Scott Cannady, no later than 10:00 am on July 13, 2015. Any revisions to the solicitation will be made only by addendum issued by the buyer.

9.10 Payment

1. To Prime Contractor:

   a. Invoices for items ordered, delivered and accepted shall be submitted by the Contractor directly to the payment address shown on the purchase order/contract. All invoices shall show the state contract number and/or purchase order number; social security number (for individual Contractors) or the federal employer identification number (for proprietorships, partnerships, and corporations).
   b. Any payment terms requiring payment in less than 30 days will be regarded as requiring payment 30 days after invoice or delivery, whichever occurs last. This shall not affect offers of discounts for payment in less than 30 days, however.
   c. All goods or services provided under this contract or purchase order, that are to be paid for with public funds, shall be billed by the Contractor at the contract price, regardless of which public Department is being billed.
   d. The following shall be deemed to be the date of payment: the date of postmark in all cases where payment is made by mail, or the date of offset when offset proceedings have been instituted as authorized under the Virginia Debt Collection Act.
   e. Unreasonable Charges: Under certain emergency procurements and for most time and material purchases, final job costs cannot be accurately determined at the time orders are placed. In such cases, Contractors should be put on notice that final payment in full is contingent on a determination of reasonableness with respect to all invoiced charges. Charges that appear to be unreasonable will be researched and challenged, and that portion of the invoice held in abeyance until a settlement can be reached. Upon determining that invoiced charges are not reasonable, the Commonwealth shall promptly notify the Contractor, in writing, as to those charges which it considers unreasonable and the basis for the determination. A Contractor may

not institute legal action unless a settlement cannot be reached within thirty (30) days of notification. The provisions of this section do not relieve the Department of its prompt payment obligations with respect to those charges that are not in dispute (Code of Virginia, § 2.2-4363).

2. To Subcontractors:

   a. A Contractor awarded a contract under this solicitation is hereby obligated:
      (1) To pay the subcontractor(s) within 7 days of the Contractor's receipt of payment from the Commonwealth for the proportionate share of the payment received for work performed by the subcontractor(s) under the contract; or
      (2) To notify the agency and the subcontractor(s), in writing, of the Contractor's intention to withhold payment and the reason.
   b. The Contractor is obligated to pay the subcontractor(s) interest at the rate of one percent per month (unless otherwise provided under the terms of the contract) on all amounts owed by the Contractor that remain unpaid 7 days following receipt of payment from the Commonwealth, except for amounts withheld as stated in (2) above. The date of mailing of any payment by U. S. Mail is deemed to be payment to the addressee. These provisions apply to each sub-tier Contractor performing under the primary contract. A Contractor obligation to pay an interest charge to a subcontractor may not be construed to be an obligation of the Commonwealth.

3. Each prime Contractor who wins an award in which provision of a Small Business Subcontracting (SWaM) Plan is a condition to the award, shall deliver to the Department, on or before request for final payment, evidence and certification of compliance (subject only to insubstantial shortfalls and to shortfalls arising from subcontractor default) with the Small Business Subcontracting (SWaM) Plan. Final payment under the contract in question may be withheld until such certification is delivered and, if necessary, confirmed by the Department or other appropriate penalties may be assessed in lieu of withholding such payment.

4. The Commonwealth of Virginia encourages Contractors and subcontractors to accept electronic and credit card payments.

9.11 Precedence of Terms

The following General Terms and Conditions: *VENDORS MANUAL,* APPLICABLE LAWS AND COURTS, ANTI-DISCRIMINATION, ETHICS IN PUBLIC CONTRACTING, IMMIGRATION REFORM AND CONTROL ACT OF 1986, DEBARMENT STATUS, ANTITRUST, MANDATORY USE OF STATE FORM AND TERMS AND CONDITIONS, CLARIFICATION OF TERMS, PAYMENT shall apply in all instances. In the event there is a conflict between any of the other General Terms and Conditions and any Special Terms and Conditions in this solicitation, the Special Terms and Conditions shall apply.

9.12 Qualifications of Offerors

The Commonwealth may make such reasonable investigations as deemed proper and necessary to determine the ability of the Offeror to perform the services/furnish the goods and the Offeror shall

furnish to the Commonwealth all such information and data for this purpose as may be requested. The Commonwealth reserves the right to inspect Offeror's physical facilities prior to award to satisfy questions regarding the Offeror's capabilities. The Commonwealth further reserves the right to reject any proposal if the evidence submitted by, or investigations of, such Offeror fails to satisfy the Commonwealth that such Offeror is properly qualified to carry out the obligations of the Contract and to provide the services and/or furnish the goods contemplated therein.

9.13 Testing And Inspection

The Commonwealth reserves the right to conduct any test/inspection it may deem advisable to ensure goods and services conform to the specifications.

9.14 Assignment of Contract

A contract shall not be assignable by the Contractor in whole or in part without the written consent of the Commonwealth. Any assignment made in violation of this section will be void.

9.15 Changes to the Contract

Changes can be made to the contract in any of the following ways:

1. The parties may agree in writing to modify the terms, conditions, or scope of the contract. Any additional goods or services to be provided shall be of a sort that is ancillary to the contract goods or services, or within the same broad product or service categories as were included in the contract award. Any increase or decrease in the price of the contract resulting from such modification shall be agreed to by the parties as a part of their written agreement to modify the scope of the contract. **In any such change to the resulting contract, no increase to the contract price shall be permitted without adequate consideration, and no waiver of any contract requirement that results in savings to the Contractor shall be permitted without adequate consideration. Pursuant to *Code of Virginia* § 2.2-4309, the value of any fixed-price contract shall not be increased via modification by more than 25% without the prior approval of the Division of Purchases and Supply of the Virginia Department of General Services.**

2. The Purchasing Agency may order changes within the general scope of the contract at any time by written notice to the contractor. Changes within the scope of the contract include, but are not limited to, things such as services to be performed, the method of packing or shipment, and the place of delivery or installation. The contractor shall comply with the notice upon receipt, unless the contractor intends to claim an adjustment to compensation, schedule, or other contractual impact that would be caused by complying with such notice, in which case the contractor shall, in writing, promptly notify the Purchasing Agency of the adjustment to be sought, and before proceeding to comply with the notice, shall await the Purchasing Agency's written decision affirming, modifying, or revoking the prior written notice. If the Purchasing Agency decides to issue a notice that requires an adjustment to compensation, the contractor shall be compensated for any additional costs incurred as the result of such order and shall give the Purchasing Agency a credit for any savings. Said compensation shall be determined by one of the following methods:

a. By mutual agreement between the parties in writing; or
b. By agreeing upon a unit price or using a unit price set forth in the contract, if the work to be done can be expressed in units, and the Contractor accounts for the number of units of work performed, subject to the Department's right to audit the Contractor's records and/or to determine the correct number of units independently; or
c. By ordering the Contractor to proceed with the work and keep a record of all costs incurred and savings realized. A markup for overhead and profit may be allowed if provided by the contract. The same markup shall be used for determining a decrease in price as the result of savings realized. The Contractor shall present the Department with all vouchers and records of expenses incurred and savings realized. The Department shall have the right to audit the records of the Contractor as it deems necessary to determine costs or savings. Any claim for an adjustment in price under this provision must be asserted by written notice to the Department within 30 days from the date of receipt of the written order from the Department. If the parties fail to agree on an amount of adjustment, the question of an increase or decrease in the contract price or time for performance shall be resolved in accordance with the procedures for resolving disputes provided by the Disputes Clause of this contract or, if there is none, in accordance with the disputes provisions of the Commonwealth of Virginia *Vendors Manual*. Neither the existence of a claim nor a dispute resolution process, litigation or any other provision of this contract shall excuse the Contractor from promptly complying with the changes ordered by the Department or with the performance of the contract generally.

9.16 Default

In case of failure to deliver goods or services in accordance with the contract terms and conditions, the Commonwealth, after due oral or written notice, may procure them from other sources and hold the Contractor responsible for any resulting additional purchase and administrative costs. This remedy shall be in addition to any other remedies, which the Commonwealth may have.

9.17 Insurance

By signing and submitting a proposal under this solicitation, the Offeror certifies that if awarded the contract, it will have the following insurance coverage at the time the contract is awarded. For construction contracts, if any subcontractors are involved, the subcontractor will have workers' compensation insurance in accordance with §§ 2.2-4332 and 65.2-800 et seq. of the Code of Virginia. The Offeror further certifies that the Contractor and any subcontractor will maintain this insurance coverage during the entire term of the contract and that all insurance coverage will be provided by insurance companies authorized to sell insurance in Virginia by the Virginia State Corporation Commission.

MINIMUM INSURANCE COVERAGES AND LIMITS REQUIRED FOR MOST CONTRACTS:

1. Workers' Compensation: statutory requirements and benefits: Coverage is compulsory for employers of three or more employees, to include the employer. Contractors who fail to notify the Commonwealth of increases in the number of employees that change their workers'

compensation requirements under the Code of Virginia during the course of the contract shall be in noncompliance with the contract.

2. Employer's Liability: $100,000.

3. Commercial General Liability: $1,000,000 per occurrence and $2,000,000 in the aggregate. Commercial General Liability is to include bodily injury and property damage, personal injury and advertising injury, products and completed operations coverage. The Commonwealth of Virginia must be named as an additional insured and so endorsed on the policy.

4. Automobile Liability: $1,000,000 combined single limit. (Required only if a motor vehicle not owned by the Commonwealth is to be used in the contract. Contractor must assure that the required coverage is maintained by the Contractor (or third party owner of such motor vehicle.)

9.18 Announcement of Award

Upon the award or the announcement of the decision to award a contract as a result of this solicitation, the purchasing agency will publicly post such notice on the DGS/DPS eVA VBO (www.eva.virginia.gov) for a minimum of 10 days.

9.19 Drug-Free Workplace

During the performance of this contract, the Contractor agrees to:

1. Provide a drug-free workplace for the Contractor's employees;
2. Post in conspicuous places, available to employees and applicants for employment, a statement notifying employees that the unlawful manufacture, sale, distribution, dispensation, possession, or use of a controlled substance or marijuana is prohibited in the Contractor's workplace and specifying the actions that will be taken against employees for violations of such prohibition;
3. State in all solicitations or advertisements for employees placed by or on behalf of the Contractor that the Contractor maintains a drug-free workplace; and
4. Include the provisions of the foregoing clauses in every subcontract or purchase order of over $10,000, so that the provisions will be binding upon each subcontractor or Contractor.

For the purposes of this section, "*drug-free workplace"* means a site for the performance of work done in connection with a specific contract awarded to a Contractor, the employees of whom are prohibited from engaging in the unlawful manufacture, sale, distribution, dispensation, possession or use of any controlled substance or marijuana during the performance of the contract.

9.20 Nondiscrimination of Contractors

A Bidder, Offeror, or Contractor shall not be discriminated against in the solicitation or award of this contract because of race, religion, color, sex, national origin, age, disability, faith-based organizational status, any other basis prohibited by state law relating to discrimination in employment or because the Bidder or Offeror employs ex-offenders unless the state agency, department or institution has made a written determination that employing ex-offenders on the specific contract is not in its best interest. If

the award of this contract is made to a faith-based organization and an individual, who applies for or receives goods, services, or disbursements provided pursuant to this contract objects to the religious character of the faith-based organization from which the individual receives or would receive the goods, services, or disbursements, the public body shall offer the individual, within a reasonable period of time after the date of his objection, access to equivalent goods, services, or disbursements from an alternative provider.

9.21 eVA Business-To-Government Vendor Registration, Contracts, and Orders

The eVA Internet electronic procurement solution, website portal www.eVA.virginia.gov, streamlines and automates government purchasing activities in the Commonwealth. The eVA portal is the gateway for vendors to conduct business with state agencies and public bodies. All vendors desiring to provide goods and/or services to the Commonwealth shall participate in the eVA Internet eprocurement solution by completing the free eVA Vendor Registration. All bidders or offerors must register in eVA and pay the Vendor Transaction Fees specified below; failure to register will result in the bid/proposal being rejected.

Vendor transaction fees are determined by the date the original purchase order is issued and the current fees are as follows:

a. For orders issued July 1, 2014 and after, the Vendor Transaction Fee is:
   (i) DSBSD-certified Small Businesses: 1%, capped at $500 per order.
   (ii) Businesses that are not DSBSD-certified Small Businesses: 1%, capped at $1,500 per order.

For orders issued prior to July 1, 2014 the vendor transaction fees can be found at www.eVA.virginia.gov.

The specified vendor transaction fee will be invoiced, by the Commonwealth of Virginia Department of General Services, approximately 30 days after the corresponding purchase order is issued and payable 30 days after the invoice date. Any adjustments (increases/decreases) will be handled through purchase order changes.

9.22 Availability of Funds

It is understood and agreed between the parties herein that the agency shall be bound hereunder only to the extent of the funds available or which may hereafter become available for the purpose of this agreement.

9.23 Set-Asides

This solicitation is set-aside for award priority to DSBSD-certified micro businesses or small businesses when designated “Micro Business Set-Aside Award Priority” or “Small Business Set-Aside Award Priority” accordingly in the solicitation. DSBSD-certified micro business or small businesses this include DSBSD-certified women-owned and minority-owned businesses when they have received the DSBSD small business certification. For purposes of award, bidders/offerors shall be deemed

micro businesses or small businesses if and only if they are certified as such by DSBSD on the due date for receipt of bids/proposals.

9.24 Bid Price-Currency

Unless stated otherwise in the solicitation, Offerors shall state offer prices in US dollars.

9.25 Authorization to Conduct Business in the Commonwealth

The Contractor organized as a stock or non-stock corporation, limited liability company, business trust, or limited partnership or registered as a registered limited liability partnership shall be authorized to transact business in the Commonwealth as a domestic or foreign business entity if so required by Title 13.1 or Title 50 of the Code of Virginia or as otherwise required by law. Any business entity described above that enters into a contract with a public body pursuant to the *Virginia Public Procurement Act* shall not allow its existence to lapse or its certificate of authority or registration to transact business in the Commonwealth, if so required under Title 13.1 or Title 50, to be revoked or cancelled at any time during the term of the contract. A public body may void any contract with a business entity if the business entity fails to remain in compliance with the provisions of this section.

10. SPECIAL TERMS AND CONDITIONS

10.1 Access to Premises

The Contractor shall allow duly authorized agents or representatives of the state or federal government, during normal business hours, access to Contractor's and subcontractors' premises, to inspect, audit, monitor or otherwise evaluate the performance of the Contractor's and subcontractor's contractual activities and shall forthwith produce all records requested as part of such review or audit. In the event right of access is requested under this section, the Contractor and subcontractor shall, upon request, provide and make available staff to assist in the audit or inspection effort, and provide adequate space on the premises to reasonably accommodate the state or federal personnel conducting the audit or inspection effort. All inspections or audits shall be conducted in a manner as will not unduly interfere with the performance of Contractor or subcontractor's activities. The Contractor shall be given 30 calendar days to respond to any preliminary findings of an audit before the Department shall finalize its findings. All information so obtained will be accorded confidential treatment as provided under applicable law.

The Department, the Office of the Attorney General of the Commonwealth of Virginia (including the Medicaid Fraud Control Unit or MFCU), the Auditor of Public Accounts of the Commonwealth of Virginia, the U.S. Department of Health and Human Services, and/or their duly authorized representatives shall be allowed access to evaluate through inspection or other means, the quality, appropriateness, and timeliness of services performed under this Contract.

10.2 Access To and Retention of Records

In addition to the requirements outlined below, the Contractor shall comply, and shall require compliance by its subcontractors with the security and confidentiality of records standards with respect to the Department's confidential records.

10.2.1 Access to Records

The Department, the Office of the Attorney General of the Commonwealth of Virginia (including the Medicaid Fraud Control Unit or MFCU), the Auditor of Public Accounts of the Commonwealth of Virginia, the Centers for Medicare and Medicaid Services (CMS), state and Federal auditors, or any of their duly authorized representatives shall have access to any books, fee schedules, documents, papers, and records of the Contractor and any of its subcontractors.

The Department, the Office of the Attorney General of the Commonwealth of Virginia (including the Medicaid Fraud Control Unit or MFCU), the Auditor of Public Accounts of the Commonwealth of Virginia, the Centers for Medicare and Medicaid Services, state and Federal auditors, or any of their duly authorized representatives, shall be allowed to inspect, copy, and audit any of the above documents, including, medical and/or financial records of the Contractor and its subcontractors.

10.2.2 Retention of Records

The Contractor shall retain all records and reports relating to this Contract for a period of 6 years after final payment is made under this Contract or in the event that this Contract is renewed 6 years after the renewal date. When an audit, litigation, or other action involving records is initiated prior to the end of said period, however, records shall be maintained for a period of 6 years following resolution of such action or longer if such action is still ongoing. Copies on electronic media or other appropriate media of the documents contemplated herein may be substituted for the originals provided that the media or other duplicating procedures are reliable and are supported by an effective retrieval system which meets legal requirements to support litigation, and to be admissible into evidence in any court of law. The records, regardless of format, remain the property of DMAS.

10.3 Confidentiality of Personally Identifiable Information

The contractor assures that information and data obtained as to personal facts and circumstances related to patients or clients will be collected and held confidential, during and following the term of this agreement, and unless disclosure is required pursuant to court order, subpoena or other regulatory authority, will not be divulged without the individual's and the agency's written consent and only in accordance with federal law or the Code of Virginia. Contractors who utilize, access, or store personally identifiable information as part of the performance of a contract are required to safeguard this information and immediately notify the agency of any breach or suspected breach in the security of such information. Contractors shall allow the agency to both participate in the investigation of incidents and exercise control over decisions regarding external reporting. Contractors and their employees working on this project may be required to sign a confidentiality statement.

10.4 Audit

The Contractor shall retain all books, records, and other documents relative to this contract for six (6) years after final payment, or until audited by the Commonwealth of Virginia, whichever is sooner. The Department, its authorized agents, and/or state auditors shall have full access to and the right to examine any of said materials during said period.

10.5 Award

Selection shall be made *of two or* more Offerors deemed to be fully qualified and best suited among those submitting proposals on the basis of the evaluation factors included in the Request for Proposals, including price, if so stated in the Request for Proposals. Negotiations shall be conducted with the Offerors so selected. Price shall be considered, but need not be the sole determining factor. After negotiations have been conducted with each Offeror so selected, the Department shall select the Offeror which, in its opinion, has made the best proposal, and shall award the contract to that Offeror. The Commonwealth may cancel this Request for Proposals or reject proposals at any time prior to an award, and is not required to furnish a statement of the reasons why a particular proposal was not deemed to be the most advantageous (Code of Virginia, § 2.2-4359D). Should the Commonwealth determine in writing and in its sole discretion that only one Offeror is fully qualified, or that one Offeror is clearly more highly qualified than the others under consideration, a contract may be negotiated and awarded to that Offeror. The award document shall be a contract incorporating by reference all the requirements, terms and conditions of the solicitation and the Contractor's proposal as negotiated.

10.6 Termination

This Contract may be terminated in whole or in part:

a. By the Department, for convenience, with not less than ninety (90) days prior written notice, which notice shall specify the effective date of the termination;
b. By the Department, in whole or in part, if funding from federal, state, or other sources is withdrawn, reduced, or limited;
c. By the Department if the Department determines that the instability of the Contractor's financial condition threatens delivery of services and continued performance of the Contractor's responsibilities; or
d. By the Department if the Department determines that the Contractor has failed to satisfactorily perform its contracted duties and responsibilities.

Each of these conditions for contract termination is described in the following paragraphs.

10.6.1 Termination for Convenience

a. The Department may terminate this contract at any time without cause, in whole or in part, upon giving the Contractor notice of such termination. Upon such termination, the Contractor shall immediately cease work and remove from the project site all of its labor forces and such of its materials as DMAS elects not to purchase or to assume in the manner hereinafter provided. Upon such termination, the Contractor shall take such steps as owner may require to assign to the owner the Contractor's interest in all

subcontracts and purchase orders designated by owner. After all such steps have been taken to DMAS' satisfaction; the Contractor shall receive as full compensation for termination and assignment the following:

(1) All amounts then otherwise due under the terms of this contract,

(2) Amounts due for work performed subsequent to the latest Request for Payment through the date of termination,

(3) Reasonable compensation for the actual cost of demobilization incurred by the Contractor as a direct result of such termination. The Contractor shall not be entitled to any compensation for lost profits or for any other type of contractual compensation or damage other than those provided by the preceding sentence. Upon payment of the forgoing, owner shall have no further obligations to the Contractor of any nature.

b. In no event shall termination for the convenience of DMAS terminate the obligations of the Contractor's surety on its payment and performance bonds.

10.6.2 Termination for Unavailable Funds

The Contractor understands and agrees that the Department shall be bound only to the extent of the funds available or which may become available for the purpose of this resulting Contract. When the Department makes a determination that funds are not adequately appropriated or otherwise unavailable to support continuance of performance of this Contract, the Department shall, in whole or in part, cancel or terminate this Contract

The Department's payment of funds for purposes of this Contract is subject to and conditioned upon the availability of funds for such purposes, whether federal and/or state funds. The Department may terminate this Contract at any time prior to the completion of this Contract, if, in the sole opinion of the Department, funding becomes unavailable for these services or such funds are restricted or reduced. In the event that funds are restricted or reduced, it is agreed by both parties that, at the sole discretion of the Department, this Contract may be amended. If the Contractor shall be unable or unwilling to provide covered services at reduced rates, the Contract shall be terminated.

No damages, losses, or expenses may be sought by the Contractor against the Department, if, in the sole determination of the Department, funds become unavailable before or after this Contract is executed. A determination by the Department that funds are not appropriated or are otherwise inadequate or unavailable to support the continuance of this Contract shall be final and conclusive.

10.6.3 Termination Because of Financial Instability

If DMAS determines that there are verifiable indicators that the Contractor will become financially unstable to the point of threatening the ability of the Department to obtain the services provided for under the Contract, DMAS shall require verification of the Contractors financial situation. If from the information DMAS determines the Contractor will inevitably become financially unstable, DMAS may terminate the contract before this occurs. If the

Contractor ceases to conduct business in the normal course, makes a general assignment for the benefit of creditors, or suffers or permits the appointment of a receiver for its business or assets, DMAS may, at its option, immediately terminate this Contract effective at the close of business on a date specified by the Department. In the event the Department elects to terminate the Contract under this provision, the Contractor shall be notified in writing, by either certified or registered mail, specifying the date of termination. The Contractor shall submit a written waiver of the licensee's rights under the federal bankruptcy laws.

In the event of the filing of a petition in bankruptcy by a principal network provider or subcontractor, the Contractor shall immediately advise the Department. The Contractor shall ensure that all tasks that have been delegated to its subcontractor(s) are performed in accordance with the terms of this Contract.

10.6.4 Termination for Default

The Department may terminate the Contract, in whole or in part, if the Department determines that the Contractor has failed to satisfactorily perform its duties and responsibilities under this Contract and is unable to cure such failure within a reasonable period of time as specified in writing by the Department, taking into consideration the gravity and nature of the default. Such termination will be referred to herein as "Termination for Default."

Upon determination by the Department that the Contractor has failed to satisfactorily perform its duties and responsibilities under this Contract, the Contractor will be notified in writing, by either certified or registered mail, of the failure and of the time period which has been established to cure such failure. If the Contractor is unable to cure the failure within the specified time period, the Department can notify the Contractor in writing within 30 calendar days of the last day of the specified time period that the Contract, has been terminated in full or in part, for default. This written notice will identify all of the Contractor's responsibilities in the case of the termination, including responsibilities related to member notification, network provider notification, refunds of advance payments, return or destruction of Department data and liability for medical claims.

In the event that DMAS determines that the Contractor's failure to perform its duties and responsibilities under this contract results in a substantial risk to the health and safety of NEMT eligible members, DMAS may terminate this contract immediately without notice.

If, after notice of termination for default, it is determined by the Department or by a court of law that the Contractor was not in default or that the Contractor's failure to perform or make progress in performance was due to causes beyond the control of and without error or negligence on the part of the Contractor or any of its subcontractors, the notice of termination will be deemed to have been issued as a termination for the convenience of the Department, and the rights and obligations of the parties will be governed accordingly.

In the event of termination for default, in full or in part, as provided for under this clause, the Department may procure or contract from other sources, upon such terms and in such manner as is deemed appropriate by the Department, supplies or services similar to those terminated,

and the Contractor will be liable for any costs for such similar supplies and services and all other damages allowed by law. In addition, the Contractor will be liable to the Department for administrative costs incurred to procure such similar supplies or services as are needed to continue operations. In the event of a termination for default prior to the start of operations, any claim the Contractor may assert will be governed by the procedures defined by the Department for handling contract termination. Nothing herein will be construed as limiting any other remedies that may be available to the Department.

In the event of a termination for default during ongoing operations, the Contractor will be paid for any outstanding payments due less any assessed damages.

10.7 Remedies for Violation, Breach, or Non-Performance of Contract

Upon receipt by the Department of evidence of substantial non-compliance by the Contractor with any of the provisions of this Contract or with state or federal laws or regulations the following remedies may be imposed.

10.7.1 Procedure for Contractor Noncompliance Notification

In the event that the Department identifies or learns of noncompliance with the terms of this contract, the Department will notify the Contractor in writing of the nature of the noncompliance. The Contractor must remedy the noncompliance within a time period established by the Department and the Department will designate a period of time, not less than 10 calendar days, in which the Contractor must provide a written response to the notification. The Department may develop or may require the Contractor to develop procedures with which the Contractor must comply to eliminate or prevent the imposition of specific remedies.

10.7.2 Remedies Available To the Department

The Department reserves the right to employ, at the Department's sole discretion, any and all remedies available at law or equity including but not limited to, payment withholds and/or termination of the contract.

10.8 Performance Bond

The Contractor shall deliver to the Department purchasing office an executed performance bond, in a form acceptable to the Department, in the amount of one month of the estimated annual contract amount as determined by the Department, with the Department as obligee. The surety shall be a surety company or companies approved by the State Corporation Commission to transact business in the Commonwealth of Virginia. No payment shall be due and payable to the Contractor, even if the contract has been performed in whole or in part, until the bond has been delivered to and approved by the Department.

10.9 Payment

The Contractor shall be prepared to provide the full range of services requested under this RFP and resultant contract, on site and be operationally ready to begin work by the implementation date established by DMAS. Upon approval of the Contractor's operational readiness and a determined start date, DMAS shall make payments as described in Section 6 of this RFP.

Each invoice submitted by the Contractor shall be subject to DMAS approval based on satisfactory performance of contracted services and compliance with all contract terms. The invoice shall contain the Federal tax identification number, the contract number and any other information subsequently required by DMAS.

10.10 Identification of Proposal Envelope

If a special envelope is not furnished, or if return in the special envelope is not possible, the signed proposal should be returned in a separate envelope or package, sealed and identified as follows:

From:_____ _____
Name of Offeror Due Date /Time

_____ _____
Street or Box Number City, State, Zip Code

_____
RFP Number

Name of Contract/Purchase Officer: _____

The envelope should be addressed as directed on Page 1 of the solicitation.

If a proposal not contained in the special envelope is mailed, the Offeror assumes the risk that the envelope, even if marked as described above, may be inadvertently opened and the information compromised, which may cause the proposal to be disqualified. Proposals may be hand delivered to the designated location in the office issuing the solicitation. No other correspondence or other proposals should be placed in the envelope.

10.11 Indemnification

Contractor agrees to indemnify, defend and hold harmless the Commonwealth of Virginia, its officers, agents, and employees from any claims, damages and actions of any kind or nature, whether at law or in equity, arising from or caused by the use of any materials, goods, or equipment of any kind or nature furnished by the Contractor/any services of any kind or nature furnished by the Contractor, provided that such liability is not attributable to the sole negligence of the Department or to failure of DMAS to use the materials, goods, or equipment in the manner already and permanently described by the Contractor on the materials, goods or equipment delivered.

10.12 Small Businesses Subcontracting and Evidence of Compliance

A. It is the goal of the Commonwealth that 42% of its purchases be made from small businesses. This includes discretionary spending in prime contracts and subcontracts. All bidders/offerors are required to submit a Small Business Subcontracting Plan. Unless the bidder/offeror is registered as a DSBSD-certified small business and where it is not practicable for any portion of the awarded contract to be subcontracted to other suppliers, the contractor is encouraged to offer such subcontracting opportunities to DSBSD-certified small businesses. This shall include DSBSD-certified women-owned and minority-owned businesses when they have received DSBSD small business certification. No bidder/offeror or subcontractor shall be considered a small business unless certified as such by the Department of Small Business and Supplier Diversity (DSBSD) by the due date for receipt of bids or proposals. If small business subcontractors are used, the prime contractor agrees to report the use of small business subcontractors by providing the purchasing office at a minimum the following information: name of small business with the DSBSD certification number, phone number, total dollar amount subcontracted, category type (small, women-owned, or minority-owned), and type of product/service provided.

B. Each prime contractor who wins an award in which a small business subcontracting plan is a condition of the award, shall deliver to the contracting agency or institution on a quarterly basis, evidence of compliance (subject only to insubstantial shortfalls and to shortfalls arising from subcontractor default) with the small business subcontracting plan. Upon completion of the contract, the contractor agrees to furnish the purchasing office at a minimum the following information: name of firm with the DSBSD certification number, phone number, total dollar amount subcontracted, category type (small, women-owned, or minority-owned), and type of product or service provided. Payment(s) may be withheld until compliance with the plan is received and confirmed by the agency or institution. The agency or institution reserves the right to pursue other appropriate remedies for non-compliance to include, but not be limited to, termination for default.

C. Each prime contractor who wins an award valued over $200,000 shall deliver to the contracting agency or institution on a quarterly basis, information on use of subcontractors that are not DSBSD-certified small businesses. Upon completion of the contract, the contractor agrees to furnish the purchasing office at a minimum the following information: name of firm, phone number, total dollar amount subcontracted, and type of product or service provided.

10.13 Prime Contractor Responsibilities

The Contractor shall be responsible for completely supervising and directing the work under this contract and all subcontractors that it may utilize, using its best skill and attention. Subcontractors who perform work under this contract shall be responsible to the prime Contractor. The Contractor agrees that it is as fully responsible for the acts and omissions of its subcontractors and of persons employed by it as it is for the acts and omissions of its own employees.

10.14 Renewal of Contract

This contract may be renewed by the Commonwealth for three successive one year periods under the terms and conditions of the original contract except as stated in 1. and 2. below. Price increases may

be negotiated only at the time of renewal. Written notice of the Commonwealth's intention to renew will be given approximately 90 calendar days prior to the expiration date of each contract period.

1. If the Commonwealth elects to exercise the option to renew the contract for an additional one-year period, the contract price(s) for the additional one year shall not exceed the contract price(s) of the original contract, **in addition to any modifications**, increased/decreased by no more than the percentage increase/decrease of the "Services" category under the Commodity and Services Group of the CPI-W section of the Consumer Price Index of the United States Bureau of Labor Statistics for the latest twelve months for which statistics are available.

2. If during any subsequent renewal periods, the Commonwealth elects to exercise the option to renew the contract, the contract price(s) for the subsequent renewal period shall not exceed the contract price(s) of the previous renewal periods, in addition to any modifications, increased/decreased by no more than the percentage increase/decrease of the Services category under the Commodity and Services Group of the CPI-W section of the Consumer Price Index of the United States Bureau of Labor Statistics for the latest twelve months for which statistics are available.

10.15 Confidentiality of Information

By submitting a proposal, the Contractor agrees that information or data obtained by the Contractor from DMAS during the course of determining and/or preparing a response to this RFP may not be used for any other purpose than determining and/or preparing the Contractor's response. Such information or data may not be disseminated or discussed for any reasons not directly related to the determination or preparation of the Contractor's response to this RFP. This paragraph does not apply to public records that would be required to be disclosed in response to a request pursuant to the Virginia Freedom of Information Act.

10.16 Business Associate Agreement (BAA)

The Contractor shall be required to enter into a DMAS-supplied Business Associate Agreement (BAA) with DMAS to comply with regulations concerning the safeguarding of protected health information (PHI) and electronic protected health information (ePHI). The Contractor shall comply, and shall ensure that any and all subcontractors comply, with all state and federal laws and regulations with regards to handling, processing, or using the Department's PHI and ePHI. This includes but is not limited to 45 CFR Parts 160 and 164 Modification to the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules Under the Health Information Technology for Economic and Clinical Health Act and the Genetic Information Nondiscrimination Act; Other Modifications to the HIPAA Rules; Final Rule, January 25, 2013 and related regulations as they pertain to this agreement.

The Contractor shall keep abreast of any future changes to the regulations. The Contractor shall comply with all current and future HIPAA regulations at no additional cost to DMAS, and agrees to comply with all terms set out in the DMAS BAA, including any future changes to the DMAS BAA. The current DMAS BAA template is available on the DMAS website at http://www.dmas.virginia.gov/Content_pgs/rfp.aspx

10.17 Obligation of Contractor

By submitting a proposal, the Contractor covenants and agrees that it has satisfied itself of the conditions to be met, and fully understands its obligations, and that it will have no right to cancel its proposal or to relief of any other nature because of its misunderstanding or lack of information.

10.18 Independent Contractor

Any Contractor awarded a contract under this RFP shall be considered an independent Contractor, and neither the Contractor, nor personnel employed by the Contractor, is to be considered an employee or agent of DMAS.

10.19 Ownership of Intellectual Property

All copyright and patent rights to all papers, reports, forms, materials, creations, or inventions created or developed in the performance specific to this contract shall become the sole property of the Commonwealth. DMAS shall have open access to the above. On request, the Contractor shall promptly provide an acknowledgement or assignment in a tangible form satisfactory to the Commonwealth to evidence the Commonwealth's sole ownership of specifically identified intellectual property created or developed in the performance of the contract.

10.20 Subsidiary-Parent Relationship

In the event the Offeror is a subsidiary or division of a parent organization, the Offeror must include in the proposal, a signed statement by the chief executive officer of the parent organization pledging the full resources of the parent organization to meet the responsibilities of the subsidiary organization under contract to the Department. DMAS must be notified within 10 calendar days of any change in ownership as well as a letter explaining how the changes affect the Contractor's relationship with the Department. Any change in ownership will not relieve the original parent of its obligation of pledging its full resources to meet the obligations of the contract with DMAS without the expressed written consent of the DMAS Director.

10.21 Business Transactions Reporting

The Contractor shall also notify the Department within 10 calendar days after any publicly announced acquisition agreement, pre-merger agreement, or pre-sale agreement impacting the Contractor's ownership. Business transactions to be disclosed include, but are not limited to:

a. Any sale, exchange, or lease of any property between the Contractor and a Party in Interest;
b. Any lending of money or other extension of credit between the Contractor and a Party in Interest; and
c. Any furnishing for consideration of goods, services (including management services) or facilities between the Contractor and a Party in Interest. Business transactions for purposes of this section do not include salaries paid to employees for services provided in the normal course of employment by the Contractor

The Contractor shall advise the Department, in writing, within 5 business days of any organizational change or major decision affecting its Medicaid business in Virginia or other states. This includes, but is not limited to, sale of existing business to other entities or a complete exit from the Medicaid market in another state or jurisdiction.

10.22 eVA Business-To-Government Contracts and Orders

The solicitation/contract will result in 1 purchase order(s) with the eVA transaction fee specified below assessed for each order.

a. For orders issued July 1, 2011 thru December 31, 2013, the Vendor Transaction Fee is:
   (i) DSBSD-certified Small Businesses: 0.75%, capped at $500 per order.
   (ii) Businesses that are not DSBSD-certified Small Businesses: 0.75%, capped at $1,500 per order.

b. For orders issued January 1, 2014, and after, the Vendor Transaction Fee is:
   (i) DSBSD-certified Small Businesses: 1%, capped at $500 per order.
   (ii) Businesses that are not DSBSD-certified Small Businesses: 1%, capped at $1,500 per order.

The specified vendor transaction fee will be invoiced by the Commonwealth of Virginia Department of General Services, approximately 30 days after the corresponding purchase order is issued and payable 30 days after the invoice date. Any adjustments (increases/decreases) will be handled through purchase order changes.

The eVA Internet electronic procurement solution, website portal www.eva.virginia.gov, streamlines and automates government purchasing activities in the Commonwealth. The portal is the gateway for vendors to conduct business with state agencies and public bodies.

Vendors desiring to provide goods and/or services to the Commonwealth shall participate in the eVA Internet e-procurement solution and agree to comply with the following: If this solicitation is for a term contract, failure to provide an electronic catalog (price list) or index page catalog for items awarded will be just cause for the Commonwealth to reject your bid/offer or terminate this contract for default. The format of this electronic catalog shall conform to the eVA Catalog Interchange Format (CIF) Specification that can be accessed and downloaded from www.eVA.virginia.gov. Contractors should email Catalog or Index Page information to eVA-catalog-manager@dgs.virginia.gov.

10.23 Compliance with Virginia Information Technology Accessibility Standard

The Contractor shall comply with all state laws and regulations with regards to accessibility to information technology equipment, software, networks, and web sites used by blind and visually impaired individuals. These accessibility standards are state law (*see* § 2.2-3502 and § 2.2-3503 of the Code of Virginia*)*. The Contractor shall comply with the Accessibility Standards at no additional cost to the Department. The Contractor must also keep abreast of any future changes to the Virginia Code as well as any subsequent revisions to the Virginia Information Technologies Standards. The current Virginia Information Technology Accessibility Standards are published on the Internet at http://www.vita.virginia.gov/library/default.aspx?id=663.

10.24 Continuity of Services

a) The Contractor recognizes that the services under this contract are vital to the Agency and must be continued without interruption and that, upon contract expiration, a successor, either the Agency or another Contractor, may continue them. The Contractor agrees:

(i) To exercise its best efforts and cooperation to effect an orderly and efficient transition to a successor;
(ii) To make all Agency owned facilities, equipment, and data available to any successor at an appropriate time prior to the expiration of the contract to facilitate transition to successor; and
(iii) That the Agency shall have final authority to resolve disputes related to the transition of the contract from the Contractor to its successor.

b) The Contractor shall, upon written notice from the Contract Officer, furnish phase-in/phase-out services for up 90 days after this contract expires and shall negotiate in good faith a plan with the successor to execute the phase-in/phase-out services. This plan shall be subject to the Contract Officer's approval.

c) The Contractor shall be reimbursed for all reasonable, pre-approved phase-in/phase-out costs (i.e., costs incurred within the agreed period after contract expiration that result from phase-in, phase-out operations) and a fee (profit) not to exceed a pro rata portion of the fee (profit) under this contract. All phase-in/phase-out work fees must be approved by the Contract Officer in writing prior to commencement of said work.

10.25 State Corporation Commission Identification Number

Pursuant to Code of Virginia, § 2.2-4311.2 subsection B, an Offeror organized or authorized to transact business in the Commonwealth pursuant to Title 13.1 or Title 50 is required to include in its proposal the identification number issued to it by the State Corporation Commission (SCC). Any Offeror that is not required to be authorized to transact business in the Commonwealth as a foreign business entity under Title 13.1 or Title 50 or as otherwise required by law is required to include in its proposal a statement describing why the Offeror is not required to be so authorized. Indicate the above information on the SCC Form provided (Reference Attachment XXIV- State Corporation Commission Form). Contractor agrees that the process by which compliance with Titles 13.1 and 50 is checked during the solicitation stage (including without limitation the SCC Form provided) is streamlined and not definitive, and the Commonwealth's use and acceptance of such form, or its acceptance of Contractor's statement describing why the Offeror was not legally required to be authorized to transact business in the Commonwealth, Shall not be conclusive of the issue and Shall not be relied upon by the Contractor as demonstrating compliance.

10.26 Subcontracts

No portion of the work shall be subcontracted without prior written consent of the Department. In the event that the Contractor desires to subcontract some part of the work specified herein, the contractor shall furnish DMAS with the names, qualifications and experience of their proposed subcontractors.

The Contractor shall, however, remain fully liable and responsible for the work to be done by its subcontractor(s) and shall assure compliance with all requirements of the contract.

10.27 Severability

Invalidity of any term of this Contract, in whole or in part, shall not affect the validity of any other term. DMAS and Contractor further agree that in the event any provision is deemed an invalid part of this Contract, they shall immediately begin negotiations for a suitable replacement provision to this RFP.

10.28 E-Verify Program

EFFECTIVE 12/1/13. Pursuant to Code of Virginia, §2.2-4308.2., any employer with more than an average of 50 employees for the previous 12 months entering into a contract in excess of $50,000 with any agency of the Commonwealth to perform work or provide services pursuant to such contract shall register and participate in the E-Verify program to verify information and work authorization of its newly hired employees performing work pursuant to such public contract. Any such employer who fails to comply with these provisions shall be debarred from contracting with any agency of the Commonwealth for a period up to one year. Such debarment shall cease upon the employer's registration and participation in the E-Verify program. If requested, the employer shall present a copy of their Maintain Company page from E-Verify to prove that they are enrolled in E-Verify.

ATTACHMENT I - REFERENCES

RFP Reference Form

Contract Name:	
Customer name and address:	
Customer contact and title:	
Contact Phone number:	
Scope of Services of Contract:	
Contract Type (fixed price, fee for service, capitation, etc):	
Contract Size (# of facilities served , # of participants served, etc):	
Amount Recovered:	
Contract Period:	
Number of Contractor staff assigned to contract:	
Any legal or contractual actions against the Offeror related to the project:	
Annual Value of Contract:	

ATTACHMENT II – SMALL BUSINESS SUBCONTRACTING PLAN

To Be Completed By Offeror and Returned With Your Cost Proposal

Note: The text of definitions section below comes directly from APSPM Annex 7-G. This text shall not be construed to reflect independent definitions or status decisions by the Department. Reference §9.1 of the RFP

It is the goal of the Commonwealth that more than 42% of its purchases be made from small businesses. All potential bidders are required to submit a Small Business Subcontracting Plan.

Small Business: "Small business (including micro)" means a business which holds a certification as such by the Virginia Department of Small Business and Supplier Diversity (DSBSD) on the due date for proposals. This shall also include DSBSD-certified women- and minority-owned businesses when they also hold a DSBSD certification as a small business on the proposal due date. Currently, DSBSD offers small business certification and micro business designation to firms that qualify under the definitions below.

Certification applications are available through DSBSD online at www.DSBSD.virginia.gov (Customer Service).

Offeror Name: _____

Preparer Name: _____ Date: _____

Instructions

A. If you are certified by the DSBSD as a micro/small business, complete only Section A of this form. This includes but is not limited to DSBSD-certified women-owned and minority-owned businesses when they have also received DSBSD small business certification.

B. If you are not a DSBSD-certified small business, complete Section B of this form. For the offeror to receive credit for the small business subcontracting plan evaluation criteria, the offeror shall identify the portions of the contract that will be subcontracted to DSBSD-certified small business for the initial contract period in Section B..

Offerors which are small businesses themselves will receive the maximum available points for the small business participation plan evaluation criterion, and do not have any further subcontracting requirements.

Offerors which are not certified small businesses will be assigned points based on proposed expenditures with DSBSD-certified small businesses for the initial contract period in relation to the offeror's total price for the initial contract period.

Points will be assigned based on each offeror's proposed subcontracting expenditures with DSBSD certified small businesses for the initial contract period as indicated in Section B in relation to the offeror's total price.

Section A

If your firm is certified by the Department of Small Business and Supplier Diversity (DSBSD), provide your certification number and the date of certification):

Certification number:_____Certification Date:_____

Section B

Populate the table below to show your firm's plans for utilization of DSBSD-certified small businesses in the performance of this contract for the initial contract period in relation to the bidder's total price for the initial contract period. Certified small businesses include but are not limited to DSBSD-certified women-owned and minority-owned businesses that have also received the DSBSD small business certification. Include plans to utilize small businesses as part of joint ventures, partnerships, subcontractors, suppliers, etc. It is important to note that these proposed participation will be incorporated into the subsequent contract and will be a requirement of the contract. Failure to obtain the proposed participation percentages may result in breach of the contract

B. Plans for Utilization of DSBSD -Certified Small Businesses for this Procurement

Micro/Small Business Name & Address **DSBSD Certificate #**	**Status if Micro/Small Business is also: Women (W), Minority (M)**	**Contact Person, Telephone & Email**	**Type of Goods and/or Services**	**Planned Involvement During Initial Period of the Contract**	**Planned Contract Dollars During Initial Period of the Contract ($ or %)**
Totals $					

ATTACHMENT III COST PROPOSAL
RFP # 2015-01
Medallion 3.0 and Commonwealth Coordinated Care (CCC)

SCHEDULE A

TOTAL COST

Category	Item	Subtotal	Price
Medallion 3.0	**Start-up/Implementation Cost**[1] *(from Schedule B)*		$
	Annual Cost *(from Schedule D)* Year 1 Year 2 Year 3	 $ $ $	
	Total Cost for Medallion 3.0 for initial **3** year contract.		$
CCC	**Start-up/Implementation Cost**[1] *(from Schedule B)*		$
	Annual Cost *(from Schedule D)* Year 1 Year 2	 $ $	
	Total Cost for CCC for initial **2** year contract.[2]		$
Total Cost Proposal[3]	Start-up/Implementation costs plus Medallion 3.0 and CCC year(s) costs.		$

Note 1: Period between date of signing contract with DMAS and date of start of operations.

Note 2: CCC costs are through December 31, 2017, the end of the demonstration. Funding for an additional contract year, through December 31, 2018 the end of the contract base period, is subject to approval by the Centers for Medicare and Medicaid Services. If approved, the Department may exercise a contract modification for continuation of CCC services.

Note 3: The Total Cost Proposal dollar amount will also be used for RFP 2015-01 Small Business Subcontracting Plan Scoring purposes.

ATTACHMENT III COST PROPOSAL
RFP # 2015-01
Medallion 3.0 and Commonwealth Coordinated Care (CCC)

SCHEDULE B

START-UP/IMPLEMENTATION COSTS

Item	Medallion 3.0	CCC	Total
A. Staffing *(by individual or staff category)*	$	$	$
B. Facilities	$	$	$
C. Hardware	$	$	$
D. Software	$	$	$
E. Supplies and Materials	$	$	$
F. Telecommunications-Helpline	$	$	$
G. Website	$	$	$
H. Equipment	$	$	$
Other Costs (itemize: add more rows as necessary)			
A.	$	$	$
B.	$	$	$
C.	$	$	$
D.	$	$	$
Total Startup/Implementation Costs[1]	$	$	$

Note 1: The total amounts for Medallion 3.0 and CCC shall be transferred to **Schedule A** in rows labeled "Start-Up and Implementation and Cost."

Note 2: Reference Section 7.3 Cost Proposal for disallowable administrative costs.

Note 3: Startup/Implementation costs will be reimbursed 30 calendar days after successful implementation as determined by DMAS.

ATTACHMENT III COST PROPOSAL
RFP # 2015-01
Medallion 3.0 and Commonwealth Coordinated Care (CCC)

SCHEDULE C

CUSTOMER SERVICE CALL PRICING

Call Tiers	Number Customer Service Calls	Unit Price per Call [1,2]		
		Year 1	Year 2	Year 3
Medallion 3.0 Tier 1	0-20,000	$	$	$
Medallion 3.0 Tier 2	20,001 +	$	$	$
CCC		$	$	N/A

Note 1: Rates shall apply to inbound and outbound Customer Service calls specific to the Virginia programs in this RFP and include calls answered and placed by a live customer service representative and answered by IVR system.

- **Inbound call**s that are abandoned prior to answer by a live Customer Service Representative and IVR calls abandoned before the caller enters data into the IVR system are not reimbursable and shall not be included in this rate table.

- **Outbound calls** include calls to verify information received or missing documents, return phone calls, and responses to external inquiries. IVR outbound calls are not anticipated and shall not be included in the unit price per call.

- In the event that high volume IVR outbound calls become necessary, please provide rate(s) in **Schedule C-1** below.

- **Transferred calls** are not reimbursable and shall not be included in this rate table.

- Inbound and outbound calls from the Department made through Contractor's administrative phone lines, i.e. not through the Helplines shall not be included in this rate table.

Note 2: Calculate a weighted Medallion 3.0 rate using weights of 90% for Tier 1 and 10% for Tier 2. Transfer the weighted Medallion 3.0 rate and the CCC rate to **Schedule D** in the column labeled "Unit Price Per Call." The weighted Medallion 3.0 rate will be used for RFP Cost Proposal evaluation purposes only.

SCHEDULE C.1

IVR OUTBOUND CALLS

# IVR Outbound calls	Rate (s)

ATTACHMENT III COST PROPOSAL
RFP # 2015-01
Medallion 3.0 and Commonwealth Coordinated Care (CCC)

SCHEDULE D

CUSTOMER SERVICE CALL PRICING

	Average Monthly Call Volume[1]	Year	Unit Price Per Call[2]	Average Monthly Cost (Unit Price Per Call x Avg. Monthly Call Volume)	Average Annual Cost[3] (Average Monthly Cost x 12 months)
Medallion 3.0	17,957	Year 1	$	$	$
	19,560	Year 2	$	$	$
	21,213	Year 3	$	$	$
CCC	4,591	Year 1	$	$	$
	4,637	Year 2	$	$	$

Note 1: Average Monthly Call Volume based on historical data and trends in **Attachment XXVI.** This number will be used for RFP Cost Proposal evaluation purposes only. It will not be used to determine actual payment values.

Note 2: Insert the calculated weighted Medallion 3.0 rate and the CCC rate from **Schedule C.**

Note 3: Average annual cost calculated by the Offeror in this table does not represent the actual amounts to be paid in the performance of the contract. Amount paid to the winning Offeror in the performance of the contract will be based on the negotiated Unit Price per Call, for each Call Tier multiplied by the actual Monthly Call Volume.

ATTACHMENT III COST PROPOSAL
RFP # 2015-01
Medallion 3.0 and Commonwealth Coordinated Care (CCC)

SCHEDULE E.1

OFFEROR'S COST DETAILS TO CUSTOMER SERVICE CALL PRICING[1] – MEDALLION 3.0

Item	Year 1	Year 2	Year 3	Total
Direct Costs[2]				
Staffing (*list staffing category*)[3]	$	$	$	$
Benefits	$	$	$	$
Temporary Labor	$	$	$	$
Facilities *(rent, utilities, building services)*	$	$	$	$
Project Materials and Supplies	$	$	$	$
Printing	$	$	$	$
Postage/Delivery	$	$	$	$
Hardware	$	$	$	$
Software	$	$	$	$
Equipment	$	$	$	$
Telecommunications- Helpline	$	$	$	$
Website	$	$	$	$
Other Direct Costs (itemize)	$	$	$	$
Subcontracts (itemize)	$	$	$	$
Indirect Costs[4] (itemize)				
	$	$	$	$
	$	$	$	$
	$	$	$	$
	$	$	$	$
TOTAL COST	$	$	$	$

Note 1: Reference Projected Call Volumes and Enrollment Projections (Attachment XXVI).

Note 2: Direct costs are costs that can be directly associated with the contract, relatively easily, with a high degree of accuracy. Travel, meals, and lodging are unallowable costs (Reference Section 6.1). Costs should not be allocated as direct if any other cost incurred for the same purpose has been listed as an indirect cost.

Note 3: List the number of full time equivalent (FTE) positions for each staffing category.

Note 4: Indirect costs are costs incurred for common or joint purposes and cannot be readily broken down and directly charged to the contract. Indirect costs typically include facilities and general administration. Indirect costs shall be limited to the portion of services applicable to the contract. Reference Section 7.3 for disallowable costs.

ATTACHMENT III COST PROPOSAL
RFP # 2015-01
Medallion 3.0 and Commonwealth Coordinated Care (CCC)

SCHEDULE E.2

OFFEROR'S COST DETAILS TO CUSTOMER SERVICE CALL PRICING[1] – CCC

Item	Year 1	Year 2	Total
Direct Costs[2]			
Staffing (*list staffing category*)[3]	$	$	$
Benefits	$	$	$
Temporary Labor	$	$	$
Facilities *(rent, utilities, building services)*	$	$	$
Project Materials and Supplies	$	$	$
Printing	$	$	$
Postage/Delivery	$	$	$
Hardware	$	$	$
Software	$	$	$
Equipment	$	$	$
Telecommunications- Helpline	$	$	$
Website	$	$	$
Other Direct Costs (itemize)	$	$	$
Subcontracts (itemize)	$	$	$
Indirect Costs[4] (itemize)			
	$	$	$
	$	$	$
	$	$	$
	$	$	$
TOTAL COST	$	$	$

Note 1: Reference Projected Call Projections and Enrollment Projections (Attachment XXVI).

Note 2: Direct costs are costs that can be directly associated with the contract, relatively easily, with a high degree of accuracy. Travel, meals, and lodging are unallowable costs (Reference Section 6.1). Costs should not be allocated as direct if any other cost incurred for the same purpose has been listed as an indirect cost.

Note 3: List the number of full time equivalent (FTE) positions for each staffing category.

Note 4: Indirect costs are costs incurred for common or joint purposes and cannot be readily broken down and directly charged to the contract. Indirect costs typically include facilities and general administration. Indirect costs shall be limited to the portion of services applicable to the contract. Reference Section 7.3 for disallowable costs.

ATTACHMENT III COST PROPOSAL
RFP # 2015-01

COST PROPOSAL - OPTIONAL SERVICES

Schedule G

CCC Mandatory Managed Care Program and Managed Long-Term Services and Supports (MLTSS)

Reference Section 3.27.1 Optional Services.

The populations below may be added, at the Department's discretion, during the period of the contract **resulting** from this RFP. Costs are for informational purposes only and will not be included in scoring of the proposals or evaluation process.

	Calendar Year 2016[1]	**Unit Price Per Call**	**Average Monthly Cost** (Unit Price Per Call x Avg. Monthly Call Volume)	**Average Annual Cost** (Average Monthly Cost x 12 months)
CCC Mandatory Program[2]	$			
Managed Long-Term Services and Supports (MLTSS)[2]	$	$	$	$

Note 1: Actual implementation and timeframes are at the discretion of the Department.

Note 2: Reference Section 3.27.1 Optional Services.

ATTACHMENT IV – MONTHLY MEDALLION 3.0 & CCC HELPLINE ACTIVITY

MEDALLION 3.0 PROGRAM 2/14 – 2/15

	Incoming Calls	Incoming Calls Answered	Average Talk Time	Outbound Calls
Feb-14	11,262	10,021	343	1,118
Mar-14	13,320	12,188	343	480
Apr-14	12,963	12,325	245	210
May-14	16,050	14,231	344	677
Jun-14	13,070	11,643	318	299
Jul-14	17,157	15,120	295	1,339
Aug-14	17,384	14,908	324	1,342
Sep-14	21,794	15,158	346	398
Oct-14	21,506	16,335	365	308
Nov-14	16,645	12,391	337	278
Dec-14	18,406	14,267	342	1,048
Jan-15	15,827	15,187	347	1,099
Feb-15	15,200	14,648	327	2,057
Annual Total	210,584	178,422	4,276	10,653

CCC PROGRAM 3/14 – 2/15

	Incoming Calls	Incoming Calls Answered	Average Talk Time	Outbound Calls
Feb-14	-	-	-	-
Mar-14	5,083	4,926	433	440
Apr-14	4,039	3,909	337	56
May-14	10,222	9,037	380	438
Jun-14	9,065	8,167	367	230
Jul-14	12,018	10,089	378	1,008
Aug-14	12,069	11,420	358	730
Sep-14	11,320	10,723	362	572
Oct-14	8,108	7,726	387	369
Nov-14	4,777	4,570	376	130
Dec-14	4,848	4,689	383	570
Jan-15	4,066	3,994	361	505
Feb-15	2,948	2,932	385	718
Annual Total	88,563	82,182	4,507	5,766

ATTACHMENT V – A CALL REASONS FOR MEDALLION 3.0 AND CCC PROGRAM CY 2014

Call Types – MEDALLION 3.0 Program – Calendar Year 2014

	Call Type Category												
	Address Change	Adoption Assistance	Complaint	Enrollment	Exemption Request	FFS	Foster Care	Fulfillment	Inquiry	Language Transfer	MCO Call	Quick Call	Verify Eligibility
Jan-14	187	162	43	2,059	3	808	134	4	2,456	275	2,429	684	1,823
Feb-14	248	177	28	2,339	0	719	130	9	3,913	225	2,279	737	1,725
Mar-14	201	235	17	2,390	1	923	124	4	3,844	162	2,325	886	1,873
Apr-14	199	257	20	2,388	2	887	195	5	3,667	107	2,269	791	2,435
May-14	212	310	29	3,566	1	592	281	4	3,946	112	2,790	970	2,232
Jun-14	114	128	21	2,315	0	455	100	3	2,998	109	1,919	1,129	2,235
Jul-14	214	74	34	2,944	4	392	76	2	4,747	243	2,690	786	2,923
Aug-14	161	80	16	3,770	2	511	61	5	4,919	171	2,573	808	2,467
Sep-14	196	73	15	4,696	1	481	131	65	3,606	255	2,812	783	2,555
Oct-14	272	54	26	5,296	1	340	102	103	3,562	152	3,022	887	2,714
Nov-14	255	56	15	4,807	0	213	33	57	3,850	94	2,047	692	1,835
Dec-14	205	38	16	3,634	0	265	33	45	3,691	122	2,597	959	2,933
Annual Total	2,464	1,644	280	40,204	15	6,586	1,400	306	45,199	2,027	29,752	10,112	27,750

Call Types – CCC Program – Calendar Year 2014

	Call Type Category												
	Address Change	Opt In	Opt Out	Complaint	MMP Call	Enrollment - Not Eligible	Fee For Service	Fulfillment	Inquiry	Language Transfer	Quick Call	Returned Mail	Verify Eligibility
Jan-14	-	-	-	-	-	-	-	-	-	-	-	-	-
Feb-14	-	-	-	-	-	-	-	-	-	-	-	-	-
Mar-14	117	659	1,080	6	507	496	296	30	1,827	37	161	53	712
Apr-14	69	653	1,080	5	104	5	82	26	967	7	7	53	55
May-14	102	1,428	3,259	7	206	11	138	37	3,407	55	10	2	236
Jun-14	129	961	2,939	4	0	223	118	33	2,909	23	62	70	803
Jul-14	130	1,013	4,071	0	0	10	119	31	4,815	17	13	257	575
Aug-14	127	982	5,006	5	136	3	138	26	4,478	19	10	368	563
Sep-14	254	942	4,399	1	177	6	135	48	4,929	17	34	310	443
Oct-14	254	605	2,337	6	231	12	124	52	3,495	13	52	304	557
Nov-14	189	297	940	5	0	1,822	122	38	2,489	50	277	184	1,024
Dec-14	112	273	917	0	0	255	75	18	1,747	8	8	134	476
Annual Total	1,483	7,813	26,028	39	1,361	2,843	1,347	339	31,063	246	634	1,735	5,444

ATTACHMENT VI – HEALTH STATUS SURVEY QUESTIONAIRE

I would like to ask you some questions about your health and the health of any other MCO Medicaid individuals in your house. The information you give me will go to the MCO. It's helpful for the MCO to know something about their new Medicaid individuals so they can begin planning for your care. Do you have a minute to answer these questions?
Some of these questions are personal, and your answers will be confidential and private- only the MCO will get this information.
Please answer for yourself and everyone in your house who is a Medicaid individual of the MCO.

Case Head:	Case Head SSN:		Case Head Language:
Last Name:	First Name:		Medicaid ID #:
Address:	City:	State/Zip:	Ph#:

1.	Gender	
2.	Date of Birth	
3.	What MCO are you choosing?	Name:
4.	Do you have a doctor you want to be your Primary Care Provider?	Name:
5.	If you have a regular doctor now, what is the doctor's name?	Names:
6.	Are you seen any specialists (doctors who specialize in a Particular field of medicine, such as a cardiologist)? [If yes, ask what they are and what they're for.]	□ Yes □ No List:
7.	Are you taking medicines that a doctor has prescribed? [If yes] What are the names?	□ Yes □ No List:
8.	Are you using any durable medical equipment, such as a hospital bed, oxygen, a wheelchair, a breathing machine- anything like that? If yes, did a doctor prescribe it?	□ Yes □ No What: □ Yes □ No
9.	Are you pregnant? [If yes], ▪ When is the baby due? ▪ Does the doctor have any special concerns about this pregnancy?	□ Yes □ No Date:
	Now I'm going to read a list of health problems, and you tell me if you or anyone in the family has that problem.	

10.	Do you have surgery planned for the future? If yes, what is the date of surgery?	□ Yes □ No Date:

11.	Are you getting home care or home hospice care? If yes, please explain.	□ Yes □ No Explanation:
12.	Are you on an organ transplant list? If yes, please explain.	□ Yes □ No Explanation:
13.	Are you getting physical therapy, or Occupational therapy, or speech therapy?	□ Yes □ No
14.	Do you have a heart condition-such as Congestive heart failure?	□ Yes □ No
15.	Do you have a lung disorder-such as asthma Or COPD?	□ Yes □ No
16.	Are you being treated by a psychiatrist or psychologist?	□ Yes □ No
17.	Do you have diabetes?	□ Yes □ No
18.	High blood pressure?	□ Yes □ No
19.	Do you have kidney disease or are you on dialysis?	□ Yes □ No
20.	Do you have cancer?	□ Yes □ No
21.	Do you smoke?	□ Yes □ No
22.	Are you living with HIV or AIDS?	□ Yes □ No
23.	Do you have a blood disease, such as sickle cell anemia or Hepatitis?	□ Yes □ No
24.	Do you have tuberculosis (TB)?	□ Yes □ No
25.	Is there a child in the house in ▪ Part C services, care coordination for children ▪ Any health department program, or Does any child receive Case Manager or Case Coordinator services?	□ Yes □ No List program and/or care coordinator:
26.	Can you think of any other special medical or mental health needs that the MCO might want to know about?	□ Yes □ No List:
27.	Have you been in the hospital in the last 12 months? [If yes] Why were you admitted?	□ Yes □ No Reason:
28.	What is your height?	Feet_____ Inches_____
29.	And your weight?	Pounds

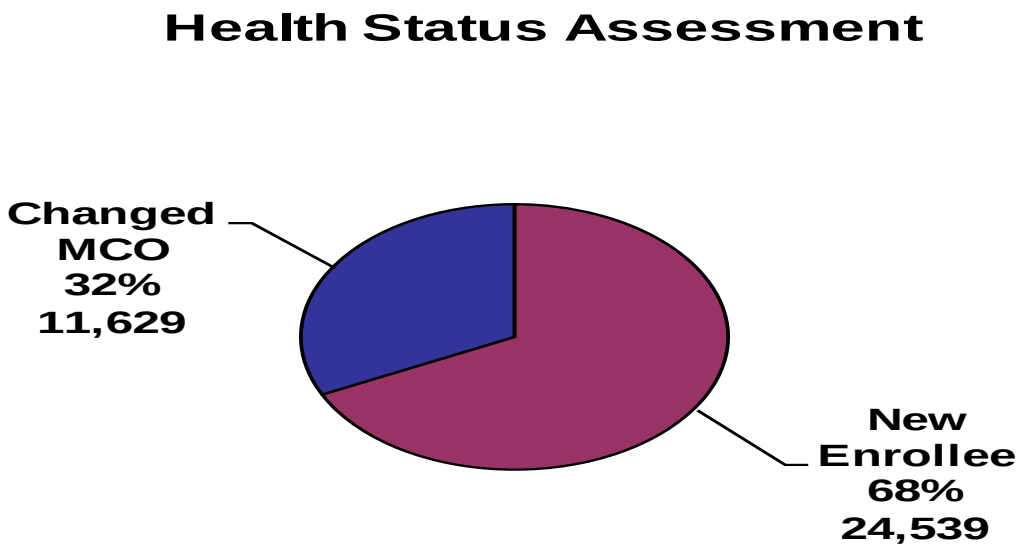
Thank you for taking the time to answer these questions.

I'll give this information to your new MCO, and they will be in touch with you soon.

If you have any questions or need assistance, please call the Managed Care Helpline at 1-800-MGD-CARE or 1-800-643-2273.

ATTACHMENT VII – MED 3.0 HEALTH STATUS ASSESSMENTS CY 2014

The pie chart below represents the Health Status Assessment Report. In Calendar 2014, enrollment service representatives conducted 36,168 Health Status Assessments. Each week the HSA's are available to the MCOs via FTP. There were 24,539 or 68% percent of HSA's conducted for new enrollees and enrollees confirming MCO assignment. 32% or 11,629 HSA's were conducted when clients transferred from one MCO to another.



ATTACHMENT VIII - SUMMARY OF MEDICAID SERVICES

The Medicaid program covers services for all eligible Medicaid individuals, including, but not limited to:

- Inpatient hospital care
- Outpatient hospital care
- Physician's services
- Outpatient psychiatric and psychological services
- Prescription drugs
- Home health services
- Clinic services
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services for children under age 21
- Podiatry
- Dental care and orthodontia care for children up to age 21
- Family-planning services
- Emergency and non-emergency medical transportation
- Hospital emergency room
- Post Stabilization Care following Emergency Services
- Medical supplies and equipment
- Nursing facility care
- Rehabilitation services
- Prosthetic devices
- Orthotic devices for children up to age 21
- Hearing aide devices for children up to age 21
- Immunizations
- Maternal and infant care coordination
- Expanded prenatal services
- Women's Health Care (pap smears, mammography, etc.)
- Prostate specific antigen (PSA) testing
- Hospice services
- Community mental health, and mental retardation services
- Organ transplantations
- Court ordered/ temporary detention ordered (TDO) services
- School based services
- Routine eye examinations (limit 1 every 2 years)
- Eyeglasses for Medicaid individuals under age 21
- Outpatient Substance Abuse Treatment
- Colorectal Cancer Screening
- Laboratory and X-ray services
- Physical and occupational Therapy
- Speech Pathology and Audiology services
- Reconstructive breast surgery

Exclusions from Medicaid covered services may include, but are not limited to: routine dental for Medicaid individuals age 21 years and over, eyeglasses for Medicaid individuals age 21 years and over, routine physicals and immunizations for Medicaid individuals age 21 years and over; abortions unless the pregnancy is life-or health-threatening to the mother; sterilizations for Medicaid individuals under 21 years of age; experimental surgical and diagnostic procedures; and inpatient hospital care in an institution for the treatment of mental disease for Medicaid individuals older than 20 and younger than 65 years of age.

ATTACHMENT IX –MEDALLION 3.0 and CCC ENROLLMENT MATERIALS

MEDALLION 3.0 Enrollment Materials Mailed by MAXIMUS by Month - Aug 2014 - Feb 2015

Items	Aug-14	Sept-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb -15
Charts	608	10	1008	353	47	10	95
MCO Brochures	6	8	7	9	9	7	19

MEDALLION 3.0 Annual Enrollment Materials Purchased - Jan, 2014 -Dec, 2014

Items	Quantity
Charts	541,500
MCO Brochures	160,000
Total	701,500

CCC Comparison Mailings (Comparison Charts, Initial, and 60-Day Letter Volume) June 2014 – February 2015

June 2014	36,915
July 2014	927
August 2014	42,990
September 2014	14,019
October 2014	17,872
November 2014	28,803
December 2014	16,172
January 2015	5,661
February 2015	7728
Total All Mailings	**171,087**

ATTACHMENT X - ASSURANCES OF FEDERAL REGULATORY COMPLIANCE

This attachment addresses Federal regulations for:

- Requiring freedom from conflict of interest;
- For the handling of specific enrollment broker activities; and,
- Requiring avoidance of conflict of interest.

The Enrollment Broker (EB) shall observe and comply with all federal and state laws collected from the Code of Federal Regulations (CFR), the State Medicaid Manual (SMM), State Medicaid Letters (SMD) and the Social Security Act (SSA) which contain provisions enacted by the Balanced Budget Act of 1997. This compliance is effective when the EB Contract is signed or which may come into effect during the term of the EB Contract. In case of contract disputes, these documents will be reviewed and considered in the order shown to resolve said disputes:

a. Federal Regulations
b. Virginia State Plan
c. Managed Care 1915 (b) Waiver
d. Medicaid State Regulations
e. Enrollment Broker Contract, including RFP, RFP amendments, EB Contractor Proposal, attachments, and Medicaid memos and manuals.

FEDERAL REGULATORY REQUIREMENTS (CMS Checklist for EB Contract Approval)

1. Independence (Reference SSA §1903(b)(4)(A); 42 CFR §438.810(a))

The Enrollment Broker and/or its subcontractors must be independent from any DMAS contracted managed care organizations (MCO) and health care provider that provides coverage in the same state in which the enrollment broker is conducting enrollment activities.

An Enrollment Broker or its subcontractor is not considered ‘‘independent’’ if it:

- Is an MCO, PCCM or other health care provider in the State;
- Is owned or controlled by an MCO, PCCM, or other health care provider in the State; or
- Owns or controls an MCO, PCCM or other health care provider in the State.

2. Freedom from Conflict of Interest (Reference SSA§1903(b)(4)(B); 42 CFR §438.810(b)

The Enrollment Broker or its subcontractor is **not** considered free from conflict of interest if any person who is the owner, employee, consultant or subcontractor has:

- Any direct or indirect financial interest in any MCO or health care provider that furnishes services in the state in which the broker or subcontractor provides enrollment services;
- Been excluded from participation under Title XVIII or XIX of the Act;
- Been debarred by any Federal agency; or
- Been, or is now, subject to civil money penalties under the Act.

3. Conflict of Interest Safeguards (Reference SSA 1932(d)(3); 42 CFR §438.58(a) and (b)

The Department administers the default enrollment process in accordance with the 42 CFR 438. The Enrollment Broker is not responsible for the default process.

4. **Enrollment Discrimination Prohibited (Reference SSA 1903(m)(2)(A)(v); 42 CFR §438.6(d)(1),(3) and (4); SMM 2090.4)**

The Enrollment Broker must provide choice counseling and enrollment activities that does not promote enrollment discrimination, such as:

- MCO must accept individuals in the order in which they apply without restriction, (unless authorized by the Regional Administrator), up to the limits set under their contract.
- The Enrollment Broker will not discriminate against individuals eligible to be covered under contract on the basis of health status or need for health services.
- The Enrollment Broker will not allow the MCO entity to discriminate against individuals eligible to enroll on the basis of race, color, or national origin, and will not use any policy or practice that has the effect of discriminating on the basis of race, color, or national origin.

5. **Compliance with Contracting Rules (Reference 42 CFR §438.6(f) (1))**

The Enrollment Broker must comply with all Federal and State laws and regulations including Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; and the Americans with Disabilities Act.

6. **Enrollment Broker Contract Functions (Reference CFR 438.810(a); 45 CFR §74.43 and 74.44; SMM 2080.6; SMM 2080.3; SMM 2080.5; SMM 2080.4; SMM 2080.10; SMM 2080.11)**

The Enrollment Broker shall adhere to the full scope of requirements described in Section 3 which includes:

- A clear and accurate description of the technical requirements for the material, product, or service to be performed.
- Contracts will be in writing.
- The population covered.
- Nonperformance, payment, and other sensitive issues.
- The contract period, procedures and criteria for extending the contract.
- Renegotiation procedures and criteria.

7. **Terminology (Reference 42 CFR 438.10(a) 42 CFR §438.810 (a)**

The Enrollment Broker shall strictly adhere to the Federal definition standards for enrollee, potential enrollee, Enrollment Broker, enrollment services, choice counseling, and enrollment activities.

8. **Information – Format Requirements (Reference SSA 1932(a)(5)(A); 42 CFR §438.10(d)(1)(i); 42 CFR.438.10 (b)(1)**

All enrollment notices, informational and instructional materials shall be available upon request and prepared in a way that is easily understood by Medicaid individuals and potential Medicaid individuals. Written material must be in an easily understood language and format.

9. **Information – Language Requirements (Reference 42 CFR §438.10(c) (3), 42 CFR §438.10(c)(5) (i);42 CFR 438.10(c)(4)**

The Enrollment Broker must make written information available in the most prevalent non-English languages, In Virginia, the only language meeting the threshold at this time

is Spanish. The Enrollment Broker must make oral interpretation services available free of charge to each enrollee and potential enrollee. Refer to #35 for more information. The Enrollment Broker must notify its Medicaid individuals:

- that oral interpretation is available for any language,
- that written information is available in Spanish, and
- how to access the interpretation services and written information.

10. Information – Alternative Formats [Reference 42 CFR §438.10(d)(1)(ii) and (d)(2]

Written material must be available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency. All Medicaid individuals and potential Medicaid individuals must be informed that information is available in alternative formats and how to access those formats.

11. Information – Potential Medicaid individuals and Medicaid individuals Non-Covered Services (Reference SSA §1932(a)(5)(D); 42 CFR §438.10(e) and (f); SMM 2088.8; SMM 2092.9)

The Contractor must ensure that each managed care enrollee or potential enrollee is informed of services available under the State Plan. The Department or MCO, where applicable, shall inform the enrollee of covered benefits including how they may be accessed.

12. Information – Potential Medicaid individuals (Reference 42 CFR §438.10(e)(1) and (e)(2); 42 CFR §438.102(c)

In following with the Department CMS 1915(b) waiver, the Department shall:

- Inform potential enrollees of their mandatory enrollment into managed care;
- Provide potential enrollees with a comparison chart of the MCOs in their area;
- Provide basic information on managed care; and,
- Provide timeframe to call the enrollment broker to make their managed care provider selection.

The Enrollment Broker shall inform enrollees:

- Of basic features of managed care;
- Which populations are excluded from enrollment or subject to mandatory enrollment;
- Of MCO responsibilities for coordination of enrollee care;
- With information specific to each MCO operating in potential enrollee's service area;
- Of benefits covered;
- Of service area; and,
- Of names, locations, telephone numbers of current contracted primary care providers.

13. Information – Enrollees (Reference 42 CFR §422.208; 42 CFR §422.210; 42 CFR §431.230; 42 CFR §438.10(f); SMD Letter 01/21/98; 42 CFR §438.10(g)(1); 42 CFR §438.10(h); 42 CFR §438.102(c); 42 CFR §438.400 through 424; 42 CFR §438.6(h); 42 CFR §438.6(i)(1); 42 CFR §438.6(i)(2); 42 CFR §489.102(a); SMM 2900; SMM 2902.2)

The Department administers the function of notifying enrollees of rights (for changing from one MCO to another), including the right to change during the first 90 days of enrollment without cause, during open enrollment, outside of the first 90 days with good

cause, and outside of open enrollment with good cause. The Enrollment Broker shall address inquiries regarding these rights from enrollees or potential enrollees.
The Enrollment Broker shall respond to questions regarding provider participation requirements as addressed in Section 3. Otherwise, the Enrollment Broker shall refer to the Department or the MCO (as appropriate) requests for detailed information regarding: names, locations, and telephone numbers of participating specialty providers accepting new patients, non-English languages spoken by current contracted providers (MCO); MCO program rules e.g., referrals and service authorizations (MCO); enrollee rights and protections (MCO Medicaid individual handbook); grievance and appeals processes (MCO Medicaid individual Handbook and Medicaid Handbook); amount, duration, and scope of benefit coverage (MCO Medicaid individual handbook); how to obtain benefits that are covered under the MCO contract (MCO Medicaid individual Handbook); how to obtain benefits that are carved out of the MCO contract (MCO Medicaid individual Handbook/DMAS Helpline); how to access emergency and post-stabilization services (MCO Medicaid individual Handbook); cost sharing responsibility under the MCO (MCO Medicaid individual ID Card); and other information not available to the Enrollment Broker that is available from the MCO or the Department directly and upon request. DMAS or the appropriate MCO shall respond to the enrollee directly.

14. **Information – Informing Enrollees of Rights (Reference 42 CFR §438.10(f)(3); 42 CFR §438.100(b)(2)(ii); 42 CFR §438.100(c)**
The Department administers and does not delegate the function of informing enrollees of rights as referenced in the Federal regulations cited above.

15. **Choice Counseling – Mechanism (Reference 42 CFR §438.10(b) (2)**
The Enrollment Broker shall have a mechanism in place to help enrollees and potential enrollees understand the basic principles of the Department's managed care programs, and to provide choice counseling to assist enrollees in making a MCO selection. Also see # 12 above.

16. **Enrollment – Process (Reference 42 CFR §434.6 (a) (3); SMM 2080.7)**
The Enrollment Broker must adhere both regulations and this RFP that specify enrollment and re-enrollment procedures for the covered populations, including a description of the processes handled by the Department and those that are required by the Enrollment Broker.

17. **Enrollment – Voluntary unless 1932 SPA or a Waiver Program (Reference 42 CFR §438.6 (d) (2)**
Enrollment in the MEDALLION 3.0 program is mandatory as approved in the CMS 1915 (b) Waiver and as described in this RFP.

18. **Enrollment – Automatic Reenrollment (Reference 42 CFR §438.56(c) (2) (iii); 42 CFR §438.56 (g); SMM 2090.5)**
The automatic re-enrollment process is administered by the Department as described in Section 3.9 of this RFP. The Enrollment Broker contract is amended to grant the recipient the right to request disenrollment upon automatic reenrollment, if the temporary loss of Medicaid eligibility has caused the recipient to miss the annual disenrollment opportunity.

19. **Enrollment Activities – Limitations on Enrollment 1932 SPA States (Reference SSA 1932(a)(2); 42 CFR §438.50 (d))**

20. **Enrollment Activity – Priority for Enrollment in 1932 SPA (Reference 42 CFR §438.50 (e).**

21. **Enrollment Activity – Enrollment by Default in 1932 SPA (Reference 42 CFR §438.50 (f).**

22. **Information – Comparison information for 1932 SPA (Reference 42 CFR §438.10(i)**
The four requirements (19-22) above are not applicable as the Department's Managed Care programs operate under the approval of a CMS 1915 (b) Waiver [not under a State Plan Amendment (SPA)].

23. **Choice of Health Professional (Reference 42 CFR §438.6(m);SMM 2090.2)**
In accordance with Section 3 of this RFP, the Enrollment Broker is required to assist the enrollee with the selection of a participating MCO by providing the names of primary care providers participating with the MCOs. The Enrollment Broker shall refer the enrollee or potential enrollee to the MCO for PCP selection.

24. **Enrollment Activity – Limitations on Changes Between Primary Care Providers (Reference 42 CFR §438.52(d); 42 CFR §438.56(c) Regulation Correction 10/25/02; SMD Letter 01/14/98)**
In accordance with Section 3 of this RFP, the Enrollment Broker is required to assist the enrollee with the selection of a participating MCO by providing the names of primary care providers participating with the MCOs. The Enrollment Broker shall refer the enrollee or potential enrollee to the MCO for PCP selection.

25. **Disenrollment – Functions (Reference 42 CFR §438.56(d)(3)(i) and (ii)**
In accordance with Section 3, the Enrollment Broker is responsible for processing all disenrollment requests that are made by enrollees (orally or in writing) within the established timeframes. Any enrollee disenrollment requests received outside of the established timeframes shall be referred by the Enrollment Broker to the Department for handling under the good-cause for disenrollment process/rules.

26. **Disenrollment – Use of Entity's Grievance Procedures (Reference 42 CFR §438.56(d)(5)(ii) and (iii); 42 CFR §438.56(e)(1)**
The Department administers the grievance system for all disenrollment related activities through the State Fair Hearing process. The Enrollment Broker is not allowed to make these determinations.

27. **Disenrollment – Annual Open Enrollment Period (Reference SSA 1932 (a) (4) (A); 42 CFR §438.56(c)(2)(ii); SMD Letter 01/21/08; SMM 2090.3)**
The Enrollment Broker is responsible to make disenrollment changes for enrollees as described in Section 3. Also refer to #18 above for disenrollment changes allowed where the enrollee has missed open enrollment during the auto-re-enrollment process.

28. **Disenrollment – During Intermediate Sanctions (Reference SSA 1932 (e)(2)(C); 42 CFR §438.56(c)(iv); 42 CFR §438.702(a)(3); SMD Letter 02/20/08)**
The Enrollment Broker shall honor any request by an enrollee to disenroll from any sanctioned MCO to another participating health plan in situations where the Department has imposed an intermediate sanction on a MCO that freezes or limits MCO enrollment.

29. **Disenrollment – Requests (Reference 42 CFR §438.56(d)(1)(i) and (ii)**
The Enrollment Broker is responsible for processing all disenrollment requests that are made by enrollees (orally or in writing) within the established timeframes. Any enrollee disenrollment requests received outside of the established timeframes shall be referred by the Enrollment Broker to the Department for handling under the good-cause for disenrollment process/rules.

30. **Disenrollment – Cause (Reference 42 CFR §438.56(d)(2)**

The Department administers the function of reviewing requests for disenrollment under good-cause guidelines in accordance with 42 CFR 438.56, including the specific bullet points listed below. The Enrollment Broker is responsible for advising Medicaid individuals who call the Managed Care Helpline about the process in which they can request good cause; taking the request for good cause orally or in writing; and submitting the recipient's request for good-cause disenrollment to DMAS for review and response. Per 42 CFR 438.56(d)(2), the following requirements are cause for disenrollment:

- The enrollee moves out of the MCOs service area.
- The plan does not, because of moral or religious objections, cover the service the enrollee seeks.
- The enrollee needs related services (for example a cesarean section and a tubal ligation) to be performed at the same time; not all related services are available within the network; and the enrollee's primary care provider or another provider determines that receiving the services separately would subject the enrollee to unnecessary risk.
- Other reasons, including but not limited to, poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the enrollee's health care needs.

31. Disenrollment – Timeframes (Reference 42 CFR §438.56(e)(1) and (2); 42 CFR §438.56(d)(4); SMM 2090.6; SMM 2090.11)

The Department administers (does not delegate to the Enrollment Broker) the function of reviewing requests for good-cause in accordance with 42 CFR 438.56. Per 42 CFR 438.56(e)(1) and (2); 42 CFR 438.56(d)(4); SMM 2090.6; SMM 2090.11 regardless of the procedures followed, the effective date of an approved disenrollment will be no later than the first day of the second month following the month in which the request was filed. If the Department fails to make the determination within these timeframes, the disenrollment is considered approved.

32. Disenrollment – Denial Notice and Appeals (Reference 42 CFR §438.56(f)

- The Department administers (does not delegate to the Enrollment Broker) the function of reviewing requests for disenrollment under good-cause guidelines in accordance with 42 CFR 438.56(f). The Department responds to requests for disenrollment in writing and the response includes the recipient's right to a State Fair Hearing for any enrollee dissatisfied with the Department's determination that there is not good cause for disenrollment. Additionally, enrollees receive an annual notice 60 days prior to their enrollment date notifying them of open enrollment.

33. Disenrollment – Reasons for Disenrollment (Reference SSA 1903(m)(2)(A)(v); SSA 1932(a)(4)(A) and (B); 42 CFR §438.56(c)(1); 42 CFR §438.56(b)(1),(2) and (3); SMD Letter 01/21/98; SMM 2090.6 through 9; SMM 2090.4; SMM 2090.12; SMM 2088.3; SMM 2080.7)

The Department administers (does not delegate to the Enrollment Broker) the function of reviewing requests for disenrollment requests submitted by the MCO. The Department's processes are in accordance with the bulleted requirements listed below.

The Enrollment Broker is responsible for conducting enrollment activities other than those that fall under "good-cause." The Enrollment Broker shall refer any requests for good cause disenrollment or any requests for disenrollment received from the MCO to the Department for review and response.

The Enrollment Broker shall honor requests for disenrollment (change from one health plan to another) outside of the annual open enrollment in circumstances where the recipient's temporary loss of Medicaid eligibility has caused the recipient to miss the annual disenrollment opportunity.

The Department handles requests for disenrollment received from the MCO in accordance with the Medicaid Contract, which sites the reasons for which the MCO may request disenrollment of an enrollee.
Under the Managed Care 1915(b) Managed Care Waiver, Virginia chooses to limit disenrollment, but provides that a recipient may request disenrollment as follows:

- For cause, at any time.
- Without cause, at the following times:
    - During the 90 days following the date of the recipient's initial enrollment with the MCO or the date the State sends the recipient notice of the enrollment, whichever is later.
    - At least once every 12 months thereafter (open enrollment).
    - Upon automatic reenrollment, if the temporary loss of Medicaid eligibility has caused the recipient to miss the annual disenrollment opportunity.
- When the State imposes the intermediate sanction specified in § 438.702(a)(3).

34. Enrollees with Special Health Care Needs Assessment (Reference 42 CFR §438.208(c)(2)

This function is not delegated to the Enrollment Broker.
The Department's MCO Contracts require that the MCO implement mechanisms to assess each Medicaid enrollee identified as having special health care needs in order to identify any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring. The assessment mechanisms must use appropriate health care professionals.

35. Language (Reference 42 CFR §438.10(c)(1)

The Department administers (does not delegate to the Enrollment Broker) the function for identifying the prevalent non-English languages spoken by enrollees and potential enrollees throughout the State. ''Prevalent'' means a non-English language spoken by a significant number or percentage of enrollees and potential enrollees in the State.

36. Race, Ethnicity, and Primary Language Identification (Reference 42 CFR §438.204(b)(2)

The Department administers (does not delegate to the Enrollment Broker) the function for identifying the race, ethnicity, and primary language spoken of each Medicaid enrollee. The Department provides this information to the MCO for each Medicaid enrollee at the time of enrollment.

37. In accordance with 42 CFR §438.56 and 42CFR 438-810, the Enrollment Broker (Contractor) Shall adhere to all of the following *"Avoidance of Conflicts of Interest Requirements."*

A. The Department intends to avoid any real or apparent conflict of interest on the part of the Contractor, subcontractors, or employees, officers and directors of the Contractor or subcontractors. Thus, DMAS reserves the right to determine, at its sole discretion, whether any information, assertion or claim received from any source indicates the existence of a real or apparent conflict of interest; and, if a conflict is found to exist, to require the Contractor to

submit additional information or a plan for resolving the conflict, subject to the Department's review and prior approval.

B. Conflicts of interest include, but are not limited to:
    1. An instance where the Contractor or any of its subcontractors, or any employee, officer, or director of the Contractor or any subcontractor has an interest, financial or otherwise, whereby the use of disclosure of information obtained while performing services under the Contract would allow for private or personal benefit or for any purpose that is contrary to the goals and objectives of the Contract.
    2. An instance where the Contractor's or any subcontractor's employees, officers, or directors use their positions for purposes that are, or give the appearance of being, motivated by a desire for private gain for themselves or others, such as those with whom they have family, business or other ties.

C. If the Department is or becomes aware of a known or suspected conflict of interest, the Contractor will be given an opportunity to submit additional information or to resolve the conflict. A Contractor with a suspected conflict of interest will have five (5) business days from the date of notification of the conflict by the Department to provide complete information regarding the suspected conflict. If a conflict of interest is determined to exist by the Department and cannot be resolved to the satisfaction of the Department, the conflict will be grounds for terminating the Contract. The Department may, at its discretion upon receipt of a written request from the Contractor, authorize an extension of the timeline indicated herein.

D. The Contractor shall submit for the Department's review and approval, a *"Conflict of Interest Disclosure Statement"* (Disclosure Statement), a *"Conflict of Interest Disclosure Statement Questionnaire"* (Questionnaire) and, as necessary, a *"Conflict of Interest Disclosure Avoidance Plan"* (Avoidance Plan), using the following timetable:
    1. Originals two (2) weeks after Contract Effective Date (CED);
    2. An update January 1st of each calendar year thereafter;
    3. The originals completed by new Program personnel within ten (10) business days of their hire; and,
    4. An update completed by Program personnel who experience a change in holdings that may create a real or apparent conflict of interest within ten (10) business days of such change.

    The Disclosure Statement shall fully describe any direct or indirect interest the Contractor, any part or any subcontractor, has in any MCO, PIHP, PAHP, PCCM or other health care provider in Virginia Medicaid (as defined in Title 42, CFR, Subpart §438.810), together with the name and position description of the Contractor, any parent, or subcontractor employee, director, consultant, or officer about whom the disclosure is being made.

    At a minimum, the Contractor's Disclosure Statement shall disclose the name and address of any and all MCO, PIHP, PAHP, PCCM or other health care provider in Virginia Medicaid in which:

    a. The Contractor, or any parent corporation, or any subcontractor, or any of the Contractor's, or any parent corporation's or any subcontractor's employee, director, consultant, or officer has a direct or indirect interest of any dollar amount.
    b. The Contractor, or any parent corporation, or any subcontractor, or any of the Contractor's or any parent corporation's or any subcontractor's employees, directors,

consultants, or officers assigned to the Contract is a director, officer, partner, trustee, employee, or holder of a management position, or is self-employed; and,

c. The Contractor, or any parent corporation, or any subcontractor, or any of the Contractor's, or any parent corporation's or any subcontractor's employees, directors, consultants, or officers assigned to the Contract, has derived any direct or indirect income within the twelve (12) months immediately prior to the submittal of a proposal.

Questionnaires shall be completed by all Contractor program personnel, and, of those with real or apparent conflict of interests, Avoidance Plans shall be completed. The Contractor shall provide copies of all Questionnaires, and as necessary, all Avoidance Plans, to the Department using the timetable described above.

The Contractor shall disclose the name of any proposed subcontractor, consultant, officer, director, or employee who was employed by the State of Virginia, the Department of Medical Assistance of Services, the Governor's Office, the Department of Health, State Controller's Office, Office of the Attorney General, and/or the Legislature as of January 2014.

If a real or apparent conflict exists, the Contractor shall, together with the Disclosure Statement and Questionnaire, submit an Avoidance Plan and procedures to hold separate such relationships and/or to safeguard against conflicts. If the Contractor has nothing to disclose under this section, it shall so certify in its Disclosure Statement.

The Contractor shall furnish to the Department the ownership and control information required by Title 42, CFR, Subpart §438.810 prior to the Contract Effective Date. The Contractor's Representative, or the selected designee, shall certify under penalty of perjury that such reports and updates to such reports are accurate, complete and current to the best of that individual's knowledge and belief unless the requirements is expressly waived by the Contracting Officer in writing.

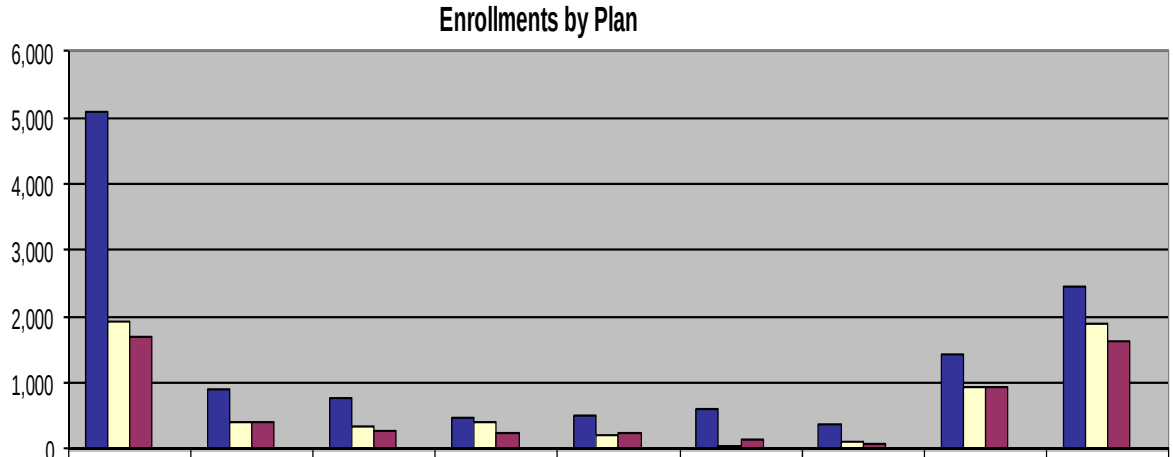
The Avoidance Plan shall include procedures to:

a. Guard against conflict of interest;
b. Hold separate any disclosed relationships or any potential conflict of interest relationships that could arise during the life of the Contract, including but not limited to such problematic matters as financial interactions, reporting, sharing of office space, staff interactions, or Contractor fulfillment of Contract responsibilities; and,
c. Ensure that the Contractor shall discharge its responsibilities and duties with disinterested skill, zeal, diligence, and that no Contractor's, parent corporation's, or subcontractor's employee, officer, director, or consultant will be in a position to exploit that position for private benefit or for other Contractor, or aren't corporation or subcontractor interests which are or may be in conflict with the Department's interests.

ATTACHMENT XI-MEDALLION 3.0 & CCC LANGUAGE LINE CALLS CY 2014

Language	Number of Calls MEDALLION 3.0	Number of Calls CCC Program	Language	Number of Calls MEDALLION 3.0	Number of Calls CCC Program
Spanish	784	38	Cantonese	6	0
Arabic	157	20	Dari	5	1
Vietnamese	143	29	Turkish	3	0
Korean	91	22	Somali	2	0
Mandarin	74	18	Haitian Creole	2	0
Farsi	58	7	Twi	2	0
Amharic	32	4	Tigrinya	1	0
Nepali	26	1	Cambodian	1	2
Russian	24	3	Punjabi	1	0
Hindi	22	5	Thai	1	0
French	17	2	Indonesian	1	0
Urdu	14	2	Japanese	1	0
Bengali	11	0	Karen	1	0
Mongolian	9	1	Gujarati	1	0
Tagalog	8	3	Bosnian	1	0
Burmese	7	0	Bulgarian	1	0
			Total	**1,507**	**158**

ATTACHMENT XII – CY 2014 MEDALLION 3.0 ENROLLMENT BY PLAN



	Anthem	Peninsula	Priority	ConventryCares	INTotal	Kaiser Permeanente	MajestaCare	Optima	VAPremier
New Enrollment	5,077	912	787	466	522	597	368	1,448	2,450
Open Enrollment	1,930	401	350	411	227	2	131	945	1,886
Transfer Enrollment	1,700	412	273	238	243	136	69	928	1,633
Total Enrollments	8,707	1,725	1,410	1,115	992	735	568	3,321	5,969

*The total number of enrollments the HelpLine conducted into MCOs during CY 2014 was 24,542. New enrollments were 12,627, open enrollment transfers were 6,283, and 90-day transfer enrollments were 5,632.

ATTACHMENT XIII – CY 2014 MEDALLION 3.0 ENROLLMENT ACTIVITY

Plan	Total Enrollments		Members Changing Plans	
Anthem	16,638	38.7%	4,819	26.9%
Anthem Peninsula	2,160	5.0%	224	1.3%
Anthem Priority	1,948	4.5%	308	1.7%
CoventryCares	1,532	3.6%	1,134	6.3%
INTotal	2,237	5.2%	1,622	9.1%
Kaiser Permanente	1,927	4.5%	927	5.2%
MajestaCare	367	0.9%	1,423	7.9%
Optima	5,616	13.1%	2,457	13.7%
VA Premier	10,595	24.6%	4,986	27.9%
Total	43,020	100.0%	17,900	100.0%

ATTACHMENT XIV - MEDALLION 3.0 COMPLAINT CATEGORIES

Complaint Codes (Major)

CO06	Access to Health Care Services/Providers
CO07	MCO Customer Service
CO08	Provider Care and Treatment
CO09	Reimbursement Issues
CO10	Administrative Issues
CO11	Transportation

Complaint Codes (Minor)

CO0601	Access to preventative care
CO0602	Access to urgent care and emergency care
CO0603	Avail and timeliness of appointments and services
CO0604	Avail of outpatient services within the network
CO0605	Availability of PCPs/specialist/behavior and MH provides
CO0606	Denial of care for serious injury (appealable)
CO0607	Denial of covered medically appropriate services (appealable)
CO0608	Denial of specialist referrals allowed
CO0609	Geographic access limitation to providers and practice
CO0610	Out-of-network access
CO0611	PCP after-hours access
CO0701	Inappropriate treatment by Medicaid individual services
CO0702	Dissatisfaction with call center treatment
CO0703	Unable to reach a Medicaid individual services representative
CO0704	Non-responsiveness to Medicaid individual issues
CO0705	Dissatisfaction with call center availability
CO0801	Appropriateness of credentials to treat
CO0802	Appropriateness of diagnosis and/or care
CO0803	Discrimination
CO0804	Failure to coordinate care
CO0805	Failure to observe standards of care-professional, state, federal
CO0806	Failure to observe sterile techniques and precaution
CO0807	Inappropriate setting for care
CO0808	PCP phone available during office hours
CO0809	Patient abandonment by PCP
CO0810	Provider did not explain treatment
CO0811	Rude and inappropriate treatment by provider
CO0812	Unable to keep accurate/confidential records
CO0813	Unexplained death
CO0814	Unnecessary test or lack of appropriate diagnostic tests
CO0815	Unsanitary physical environment
CO0816	Waited too long in office
CO0901	Enrollee billed for covered services (appealable)
CO0902	Enrollee billed for missed appointments (appealable)

CO0903	Enrollee charged inappropriately for co-payments
CO0904	Provider claim denied incorrectly
CO0905	Provider claim processed incorrectly
CO0906	Provider did not get paid promptly
CO1001	Did not receive Medicaid individual handbook and/or other notices
CO1002	Did not receive Medicaid individual ID card
CO1003	Eligibility is wrong
CO1004	Did not receive Medicaid ID card
CO1005	Enroll provisions to allow transfers to other providers
CO1006	Enrollment/Disenrollment decision not implemented
CO1007	Failure to adequately document & make avail denial reasons (appealable)
CO1008	Incorrect information on Medicaid individual card
CO1009	Limitations on covered hospital length of stays (appealable)
CO1010	Notification of EOC changes & mandated benefits
CO1011	Organ transplant criteria questioned (appealable)
CO1012	Pharmaceuticals – use of generic vs. brand names
CO1013	Timeliness of pre-auth reviews based on urgency (appealable)
CO1014	Access to MCO complaint and grievance procedures
CO1101	Transportation provider did not pick up Medicaid individual
CO1102	Rude transportation provider
CO1103	Waited too long for transportation provider
CO1104	No seat belts or lack of functional seatbelts
CO1105	Driver not identified by nametag
CO1106	Vehicle issue

ATTACHMENT XV – MEDALLION 3.0 MCO CHANGE REASONS

Individual choice had been pre-assigned to another

Diff MCO has program that better serves client's needs

Has facility that better serves client's needs

PCP in another MCO

Pharmacy in another MCO

Specialist in another MCO

Misleading information presented by MCO

Moving to another area where MCO does not service

As part of the resolution of a formal grievance

Client req specialized care for a chronic condition

Problems with MCOs transportation services

MCO would not pay for a particular treatment

Problems getting prescriptions

Unable to get a specialist referral

Can't find a doctor taking new patients

PCP has left MCO

Long wait for an appointment

Language barriers with providers

PCP no longer accepts patients under the MCO

Client enrolled in error

Want all family Medicaid individuals on the same MCO

MCO or PCP within MCO will not allow 2nd opinion

PCP instructed Medicaid individual to change MCO

Facility for mentally retarded over 30 days

***patient to follow prescribed treatment

Abusive or threatening conduct by client

Falsification of enrollment material by client

MCO – no longer participates

Asked, No Reason Given

Referred by Family/Friend

PCP in plan cannot treat a particular condition

Loss of Medicaid eligibility

ATTACHMENT XVI – MEDALLION 3.0 OPEN ENROLLMENT DATES

Managed Care Open Enrollment

Region	Letter Sent (EOM)	Call Time	Effective Date
Central Virginia	January	Feb-Mar	April 1
Tidewater	April	May-June	July 1
Northern Virginia	June	July-Aug	Sept 1
Western	August	Sept-Oct	Nov 1
Roanoke/Alleghany	November	Dec-Jan	Feb 1
Far Southwest	April	May-June	July 1

ATTACHMENT XVII – MEDALLION 3.0 EXEMPTION FORM

MANAGED CARE EXEMPTION FORM

Return to: HMO Unit

_____
Re-enrollment Date (If applicable)

_____ Recipient Name	_____/_____/_____/_____ Recipient Medicaid I.D. Number
_____ _____ City/County of residence + FIPS code	_____ Recipient Telephone Number
_____ Requester Name (If different from above)	_____ Requester Telephone Number
HMO from which recipient is being exempted _____	NOTES:
REASON FOR EXEMPTION	**DETAILS**
(1) TPL (doesn't qualify for waiver because of TPL)	_____ (yes/no) (attach CICS screens)
(2) 3rd Trimester Pregnancy (last 3 months at time of HMO enrollment)	_____ _____ (yes/no) Due Date _____ Delivering Physician
(3) Out of Area	_____ (yes/no)

(Recipient is inpatient at program not on eligibility file)	(attach CICS recipient address screen)
(4) Foster Child/Subsidized Adoption (Ask DSS to fax verification to attach to form)	_____ (yes/no) _____ Name of Child
(5) Individual Consideration (Good Cause as described in Article VI of MMII & OPTIONS Contracts)	Describe:
(6) 9th Month of Pregnancy	_____ _____ (yes/no) Due Date _____ Delivering Physician
(7) TPL Managed Care Conflict	CICS identified the following message upon entry:

_____ _____
Name of Person Taking Request Date of Request

ATTACHMENT XVIII – MEDALLION 3.0 EXCLUSION LIST

EXCLUSIONS FROM MEDALLION II PARTICIPATION

The Contractor shall cover all Medicaid eligible members, with the exception of excluded members as defined in 12 VAC 30-120-370 B. The Department shall exclude members who meet at least one of the exclusion criteria listed below:

A. Members who are inpatients in State mental hospitals including but not limited to those listed below:

A.I Catawba Hospital,

A.II Central State Hospital,

A.III The Commonwealth Center for Children and Adolescents,

A.IV Eastern State Hospital,

A.V HW Davis Medical Center,

A.VI Northern Virginia Mental Health Institution,

A.VII Piedmont Geriatric Hospital

A.VIII Southern Virginia Mental Health Institution,

A.IX Southwestern State HM&S,

A.X Southwestern VA Mental Health Institution,

A.XI Western State HM&S, and

A.XII Western State Hospital.

B. Members who are approved by the Department as inpatients in long-stay hospitals (the Department recognizes two facilities as long-stay hospitals: Lake Taylor [Norfolk] and Hospital for Sick Children [Washington, DC]), nursing facilities, or intermediate care facilities for the mentally retarded.

C. Members who are placed on spend-down.

D. Members who are participating in Federal Waiver Programs for home-based and community based Medicaid coverage prior to managed care enrollment.

E. Members, other than students, who permanently live outside their area of residence for greater than sixty (60) consecutive days, except those members placed there for medically necessary services funded by the Contractor or other MCO.

F. Members who receive hospice services in accordance with Department criteria.

G. Members with other comprehensive group or individual health insurance coverage, including Medicare, insurance provided to military dependents, and any insurance purchased through the Health Insurance Premium Payment Program, except as set forth in this Contract. (Veteran's Affairs (VA) benefits are not considered "other insurance" and do not qualify as an exclusion from Managed Care).

H. Newly eligible members who are in their third trimester of pregnancy and who request exclusion by the 15th of the month in which their enrollment becomes effective. Exclusion may be granted only if the member's obstetrical provider (physician, certified nurse midwife or

hospital) does not participate with any of the state-contracted MCOs. Exclusion requests under this paragraph shall be made by the member, MCO, or obstetrical provider.

I. Members under age 21 who are approved for DMAS residential facility Level C programs as defined in 12VAC 30-130-860.

J. Members who have been pre-assigned to the Contractor but whose physician certifies a life expectancy of six (6) months or less may request exclusion from Medallion II. Requests must be made during the pre-assignment period.

K. Members who are inpatients in hospitals, other than those listed in 5.2.A and 5.2.B above, at the scheduled time of enrollment or who are scheduled for inpatient hospital stay or surgery within 30 calendar days of the enrollment effective date. The exclusion shall remain effective until the first day of the month following discharge. This does not apply to newborns unless there is a break in coverage. (See also Section 5.9 "Delay of Enrollment due to Hospitalization").

L. Certain members between birth and age three certified by the Department of Behavioral Health and Developmental Services as eligible for services pursuant to Part C of the Individuals with Disabilities Education Act (20 U.S.C. § 1471 et. Seq.), who are granted an exception by the Department.

M. Members who are eligible and enrolled in the Virginia Birth-Related Neurological Injury Compensation Fund, commonly known as the Birth Injury Fund.

N. Members who have an eligibility period that is less than three (3) months

O. Members who are enrolled in the Commonwealth's Title XXI SCHIP program.

P. Members who have an eligibility period that is only retroactive.

Members enrolled with a MCO that subsequently meets one or more of these criteria during MCO enrollment shall be excluded from MCO participation as appropriate by DMAS, with the exception of those who subsequently become members in the federal long-term waiver programs, as otherwise defined elsewhere in this section, for home and community-based Medicaid coverage (AIDS, Individual and Family Development Disabilities Supports, Individuals with Intellectual disability, Elderly or Disabled with Consumer Direction, Day Support, Alzheimer's, or as may be amended from time to time). These members shall receive acute and primary medical services via the MCO and shall receive waiver services and related transportation to waiver services via the fee-for-service program.

The Department shall, upon new State or Federal regulations or Department policy, exclude other members as appropriate.

ATTACHMENT XIX – Service Level Agreements, Services Measures, Performance Standards and Penalties

For purposes of this RFP, "Quality" defines a level of service that accomplishes the following objectives:

- Provides accurate, timely and high quality enrollment services to Medicaid Individuals Members
- Meets or exceeds performance standards established in the Service Level Agreements (SLAs)
- Provides timely and accurate enrollment additions and changes
- Provides qualitative and accurate information on MCO plans for members to make informed choice
- Minimizes Member service complaints with timely resolutions.

The Contractor shall meet or exceed all of the Service Level Agreements (SLAs) in this RFP during the term of the contract. The reports required to measure performance against SLA standards are outlined in Section 4 of this RFP. The SLAs subject to specified performance penalties are itemized in the Table below:

Number	RFP Section	Operational Task	Service Measure	Performance Standard
SLA001 Call Center Performance Standards	Section 3.6	Call Center performance shall meet or exceed metrics set forth in the following table:		
		Call Center performance – blocked calls	blockage rate	2% blockage rate measured each month
		Call abandonment rate	Total number of all calls abandoned before reaching a live voice plus the number of blocked calls (received by a busy signal) divided by the total number of all calls received regardless of source or reason.	The rate of abandoned calls shall not exceed 5%, measured each month

Number	RFP Section	Operational Task	Service Measure	Performance Standard
		Call wait time	Total wait time in the queue	Wait time of no more than 60 seconds in queue to speak with a live person, measured each month.
SLA 002 Enrollment Additions and Changes	Section 3.9	Processing enrollment adds and changes	Complete enrollment requests correctly on the same day of the request	95% of complete and accurate enrollment requests processed the same day, measured each month
SLA 003 Completion of Health Status Assessments	Section 3.38	Completion of Health Status Assessments (HSAs) for newly eligible Medicaid Individuals,	Complete HSAs during call transaction for new member.	95% of HSAs completed on all newly eligible Medicaid individuals who contact the Call Center, measured each month.

For each of the monthly SLAs that are not met in any calendar month, there shall be a one percent (1%) reduction of the Contractor's total payment for the subsequent calendar month. The maximum possible reduction shall be five percent (5%) each month for the monthly standards. The Contractor shall submit monthly reports as described in Section 4 of this RFP in a format that is mutually agreed upon detailing performance. Furthermore, the Contractor shall agree to allow DMAS to perform quality audits as deemed necessary by DMAS.

In the proposal, the Contractor shall submit a Quality Assurance Plan that outlines how performance of all SLAs shall be monitored and achieved. The plan shall include training of the staff charged with service delivery, oversight of the staff by management, and accurate coding and reporting of performance data. The plan shall also include quarterly review of all policy and procedure manuals, training materials, and other service documentation to assure that these are up to date. The Plan shall also include specifics of the provider incentive program.

ATTACHMENT XX – SAMPLE MONTHLY CALL CENTER REPORTS

MEDALLION 3.0 Monthly Report

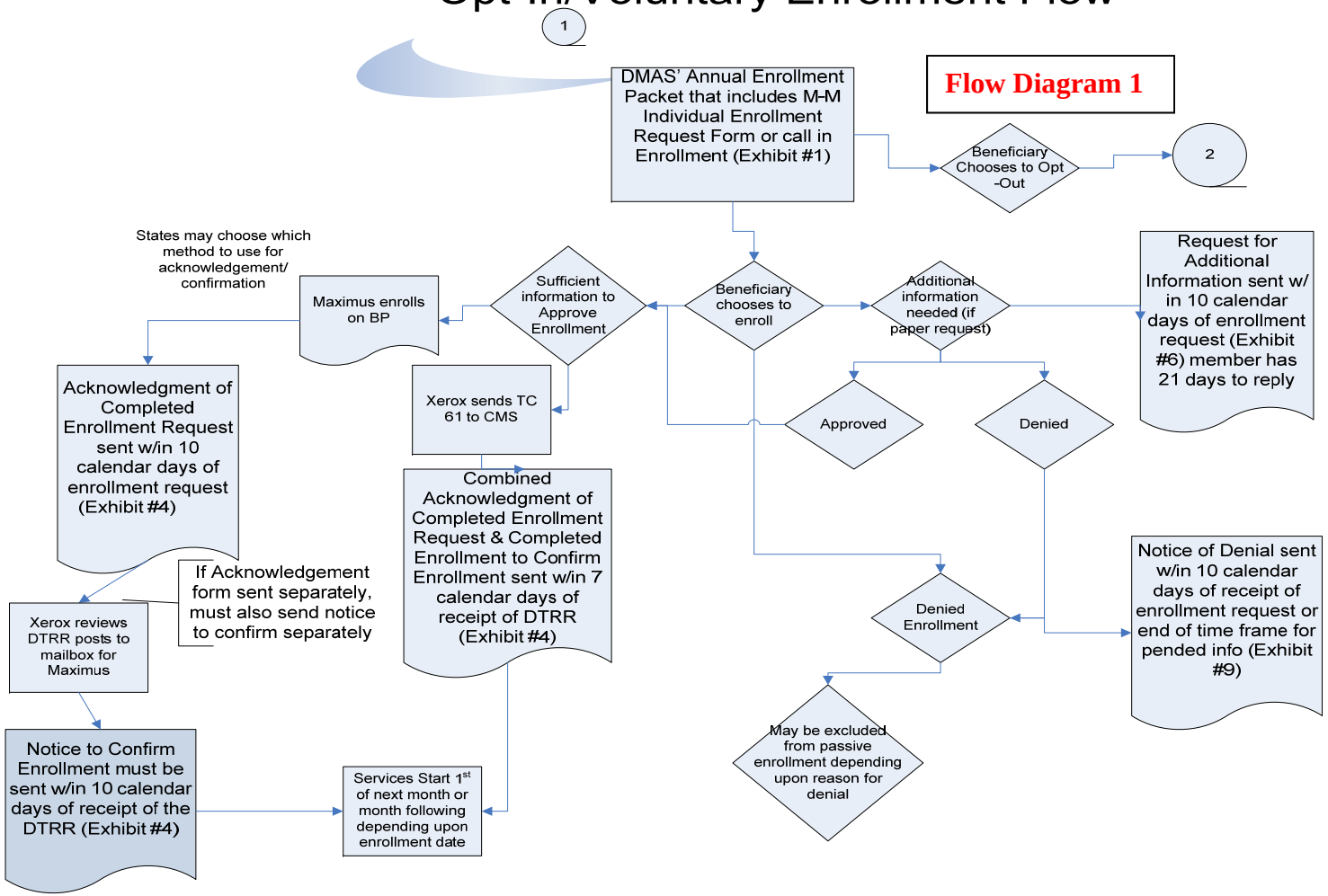
DATE								AVERAGE (seconds)					
		Incoming Calls	Total Calls Answered	Abandon <15 Sec	Abandon >15 Sec	Abandon Rate	Total Abandon	Average Wait Time	Average Talk Time	Average Abandon Time	Outgoing Calls	VA Agents Logged In	IN Agents Logged In
Wed	4/1/2015	715	707	1	7	0.98%	8	5	286	72	125	16.0	0.0
Thurs	4/2/2015	522	522	0	0	0.00%	0	2	288	0	148	16.0	0.0
Fri	4/3/2015	487	482	1	4	0.82%	5	4	295	113	130	14.0	0.0
Week Total		1724	1711	2	11	0.64%	13	4	289	88	403	15.3	0.0
Mon	4/6/2015	673	671	1	1	0.15%	2	2	335	42	157	19.0	0.0
Tues	4/7/2015	646	637	2	7	1.08%	9	6	356	36	164	19.0	0.0
Wed	4/8/2015	592	584	1	7	1.18%	8	8	340	64	138	16.0	0.0
Thurs	4/9/2015	530	523	2	5	0.94%	7	12	327	67	118	12.0	0.0
Fri	4/10/2015	480	478	1	1	0.21%	2	5	358	37	121	16.0	0.0
Week Total		2921	2893	7	21	0.72%	28	6	343	52	698	16.4	0.0
Mon	4/13/2015	956	914	7	35	3.66%	42	31	338	86	215	19.0	0.0
Tues	4/14/2015	764	731	5	28	3.66%	33	26	345	89	198	16.0	0.0
Wed	4/15/2015	592	591	0	1	0.17%	1	3	309	75	138	16.0	0.0
Thurs	4/16/2015	554	546	0	8	1.44%	8	14	331	70	112	12.0	0.0
Fri	4/17/2015	517	509	2	6	1.16%	8	7	352	28	124	16.0	0.0
Week Total		3383	3291	14	78	2.31%	92	18	335	81	787	15.8	0.0
Mon	4/20/2015	777	727	4	46	5.92%	50	37	340	79	173	12.0	0.0
Tues	4/21/2015	591	583	1	7	1.18%	8	8	320	41	141	16.0	0.0
Wed	4/22/2015	479	479	0	0	0.00%	0	0	315	0	116	16.0	0.0
Thurs	4/23/2015	505	501	0	4	0.79%	4	2	327	71	131	16.0	0.0
Fri	4/24/2015	653	624	6	23	3.52%	29	25	328	68	162	12.0	0.0
Week Total		3005	2914	11	80	2.66%	91	17	327	72	723	14.4	0.0
Mon	4/27/2015	1275	1113	19	143	11.22%	162	83	348	105	313	19.0	0.0
Tues	4/28/2015	821	790	5	26	3.17%	31	23	353	66	237	16.0	0.0
Wednesday	4/29/2015	747	731	5	11	1.47%	16	11	326	57	209	16.0	0.0
Thursday	4/30/2015	870	789	7	74	8.51%	81	56	359	93	225	16.0	0.0
Week Total		3713	3423	36	254	6.84%	290	21	234	36	984	16.8	0.0
TOTAL		**14746**	**14232**	**70**	**444**	**3.01%**	**514**	**14**	**305**	**53**	**3595**	**15.7**	**0.0**

CCC Monthly Report

DATE								AVERAGE (seconds)					
		Incoming Calls	Total Calls Answered	Abandon <15 Sec	Abandon >15 Sec	Abandon Rate	Total Abandon	Average Wait Time	Average Talk Time	Average Abandon Time	Outgoing Calls	Enroll/ Disenroll Mail	CCC Agents Logged In
Mon	5/5/2014	1327	870	0	457	34.44%	457	280	363	209	72	4	21.0
Tues	5/6/2014	928	657	0	271	29.20%	271	224	402	179	140	88	22.0
Wed	5/7/2014	692	580	0	112	16.18%	112	157	356	161	25	130	14.0
Thurs	5/8/2014	546	484	0	62	11.36%	62	124	409	160	15	43	12.0
Fri	5/9/2014	379	371	0	8	2.11%	8	45	392	134	6	27	13.0
Week Total		3872	2962	0	910	23.50%	910	189	381	190	258	292	16.4
Mon	5/12/2014	500	474	0	26	5.20%	26	68	387	135	38	77	14.0
Tues	5/13/2014	394	380	0	14	3.55%	14	58	374	111	5	17	12.0
Wed	5/14/2014	334	331	0	3	0.90%	3	36	365	245	6	29	12.0
Thurs	5/15/2014	369	357	0	12	3.25%	12	46	373	155	11	34	14.0
Fri	5/16/2014	326	321	0	5	1.53%	5	44	386	167	14	131	10.0
Week Total		1923	1863	0	60	3.12%	60	52	378	142	74	288	12.4
Mon	5/19/2014	405	398	0	7	1.73%	7	37	386	74	9	30	13.0
Tues	5/20/2014	327	324	0	3	0.92%	3	27	389	113	11	25	14.0
Wed	5/21/2014	290	288	0	2	0.69%	2	37	386	121	6	32	13.0
Thur	5/22/2014	287	286	0	1	0.35%	1	35	387	106	7	104	14.0
Frid	5/23/2014	287	284	0	3	1.05%	3	36	377	130	5	10	11.0
Week Total		1596	1580	0	16	1.00%	16	34	385	100	38	201	13.0
Mon	5/26/2014												
Tues	5/27/2014	462	446	0	16	3.46%	16	78	356	142	30	21	10.0
Wed	5/28/2014	350	345	0	5	1.43%	5	42	360	83	10	34	10.0
Thurs	5/29/2014	359	341	0	18	5.01%	18	73	366	81	10	58	10.0
Fri	5/30/2014	383	370	0	13	3.39%	13	47	368	119	10	11	11.0
Week Total		1554	1502	0	52	3.35%	52	61	362	109	60	124	10.3
TOTAL		**8945**	**7907**	**0**	**1038**	**11.60%**	**1038**	**101**	**378**	**182**	**430**	**905**	**13.2**

ATTACHMENT XXI – CCC ENROLLMENT FLOW CHARTS

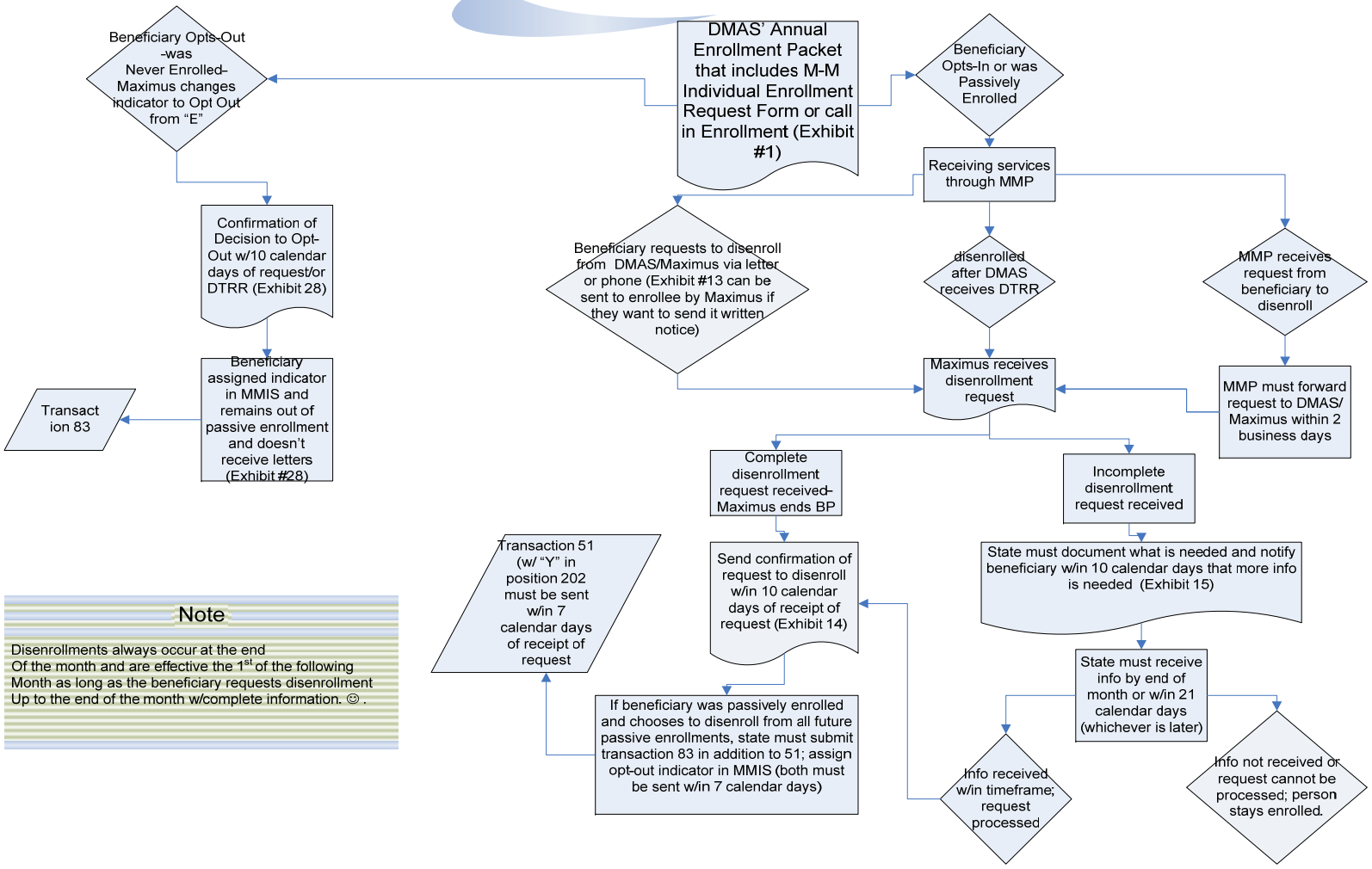
Opt-In/Voluntary Enrollment Flow



Opt-Out Flow
Voluntary Disenrollments

2

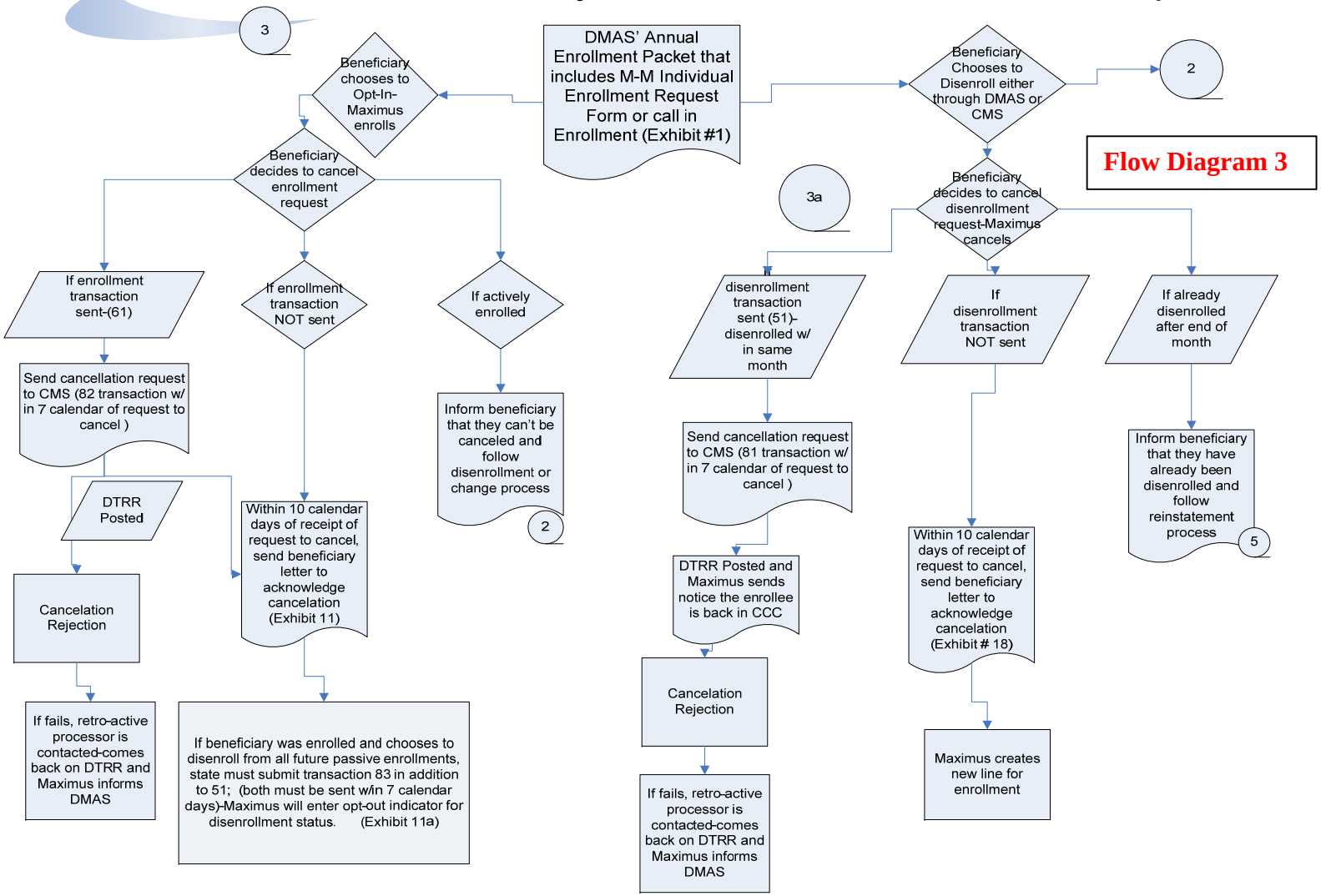
Flow Diagram 2



Note

Disenrollments always occur at the end
Of the month and are effective the 1st of the following
Month as long as the beneficiary requests disenrollment
Up to the end of the month w/complete information. ☺ .

Cancellation of Voluntary Enrollment/Disenrollment Requests

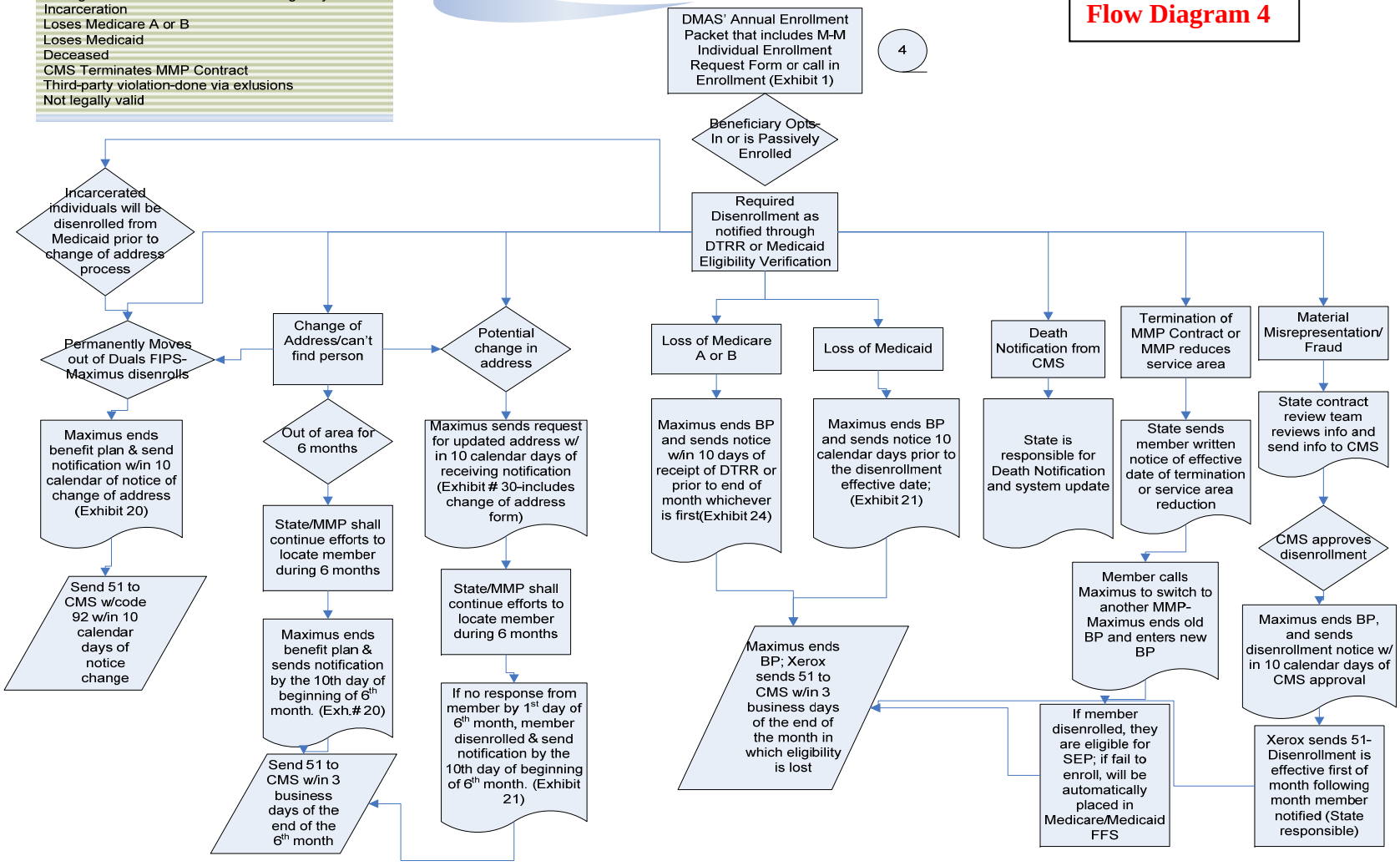


Involuntary Disenrollment Flow

Flow Diagram 4

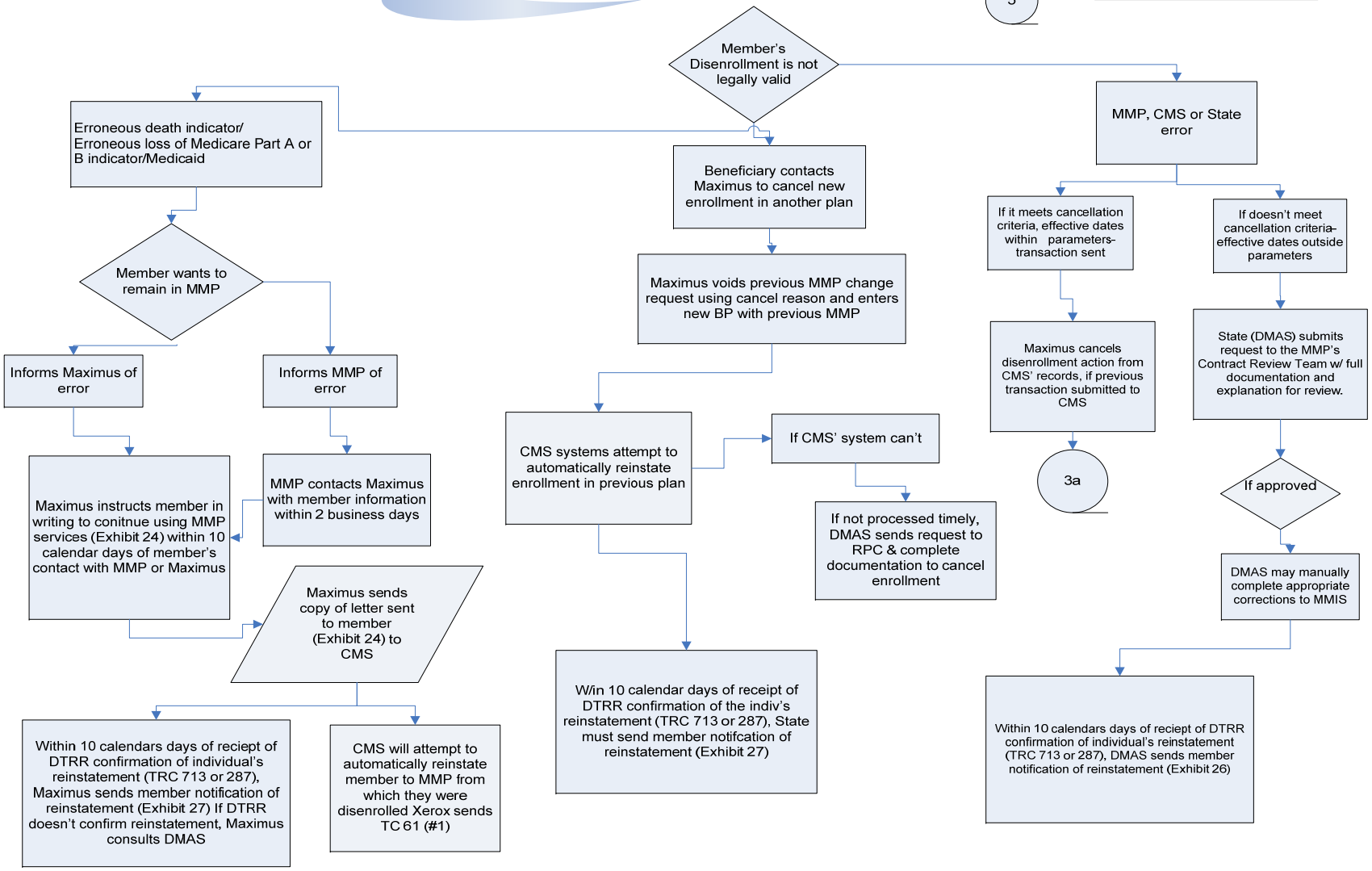
Reasons for Required Disenrollment

Change in Residence that causes ineligibility
Incarceration
Loses Medicare A or B
Loses Medicaid
Deceased
CMS Terminates MMP Contract
Third-party violation-done via exlusions
Not legally valid



Reinstatements Flow

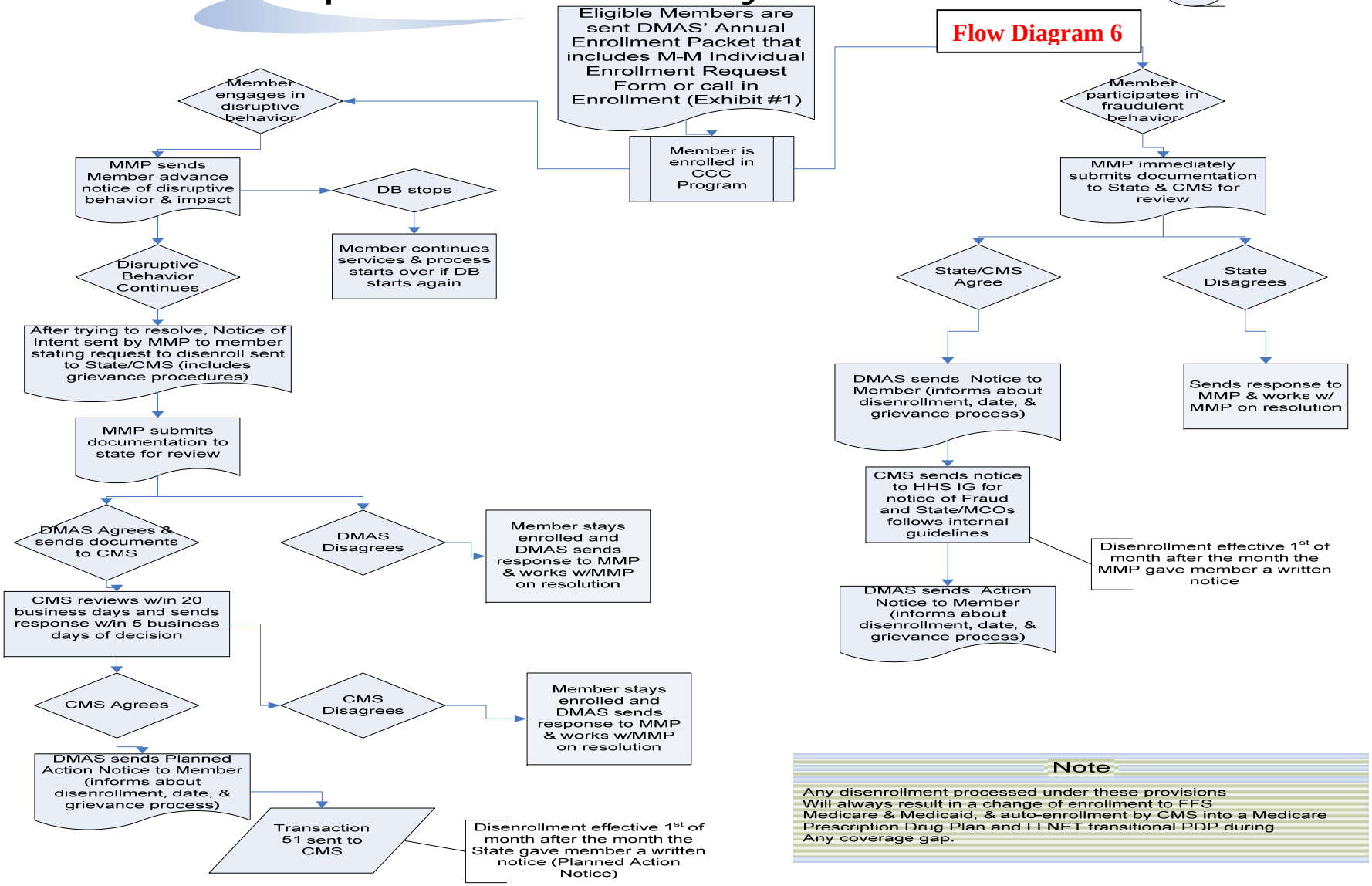
Flow Diagram 5



Flow Diagram 6

Optional Involuntary Disenrollments

6

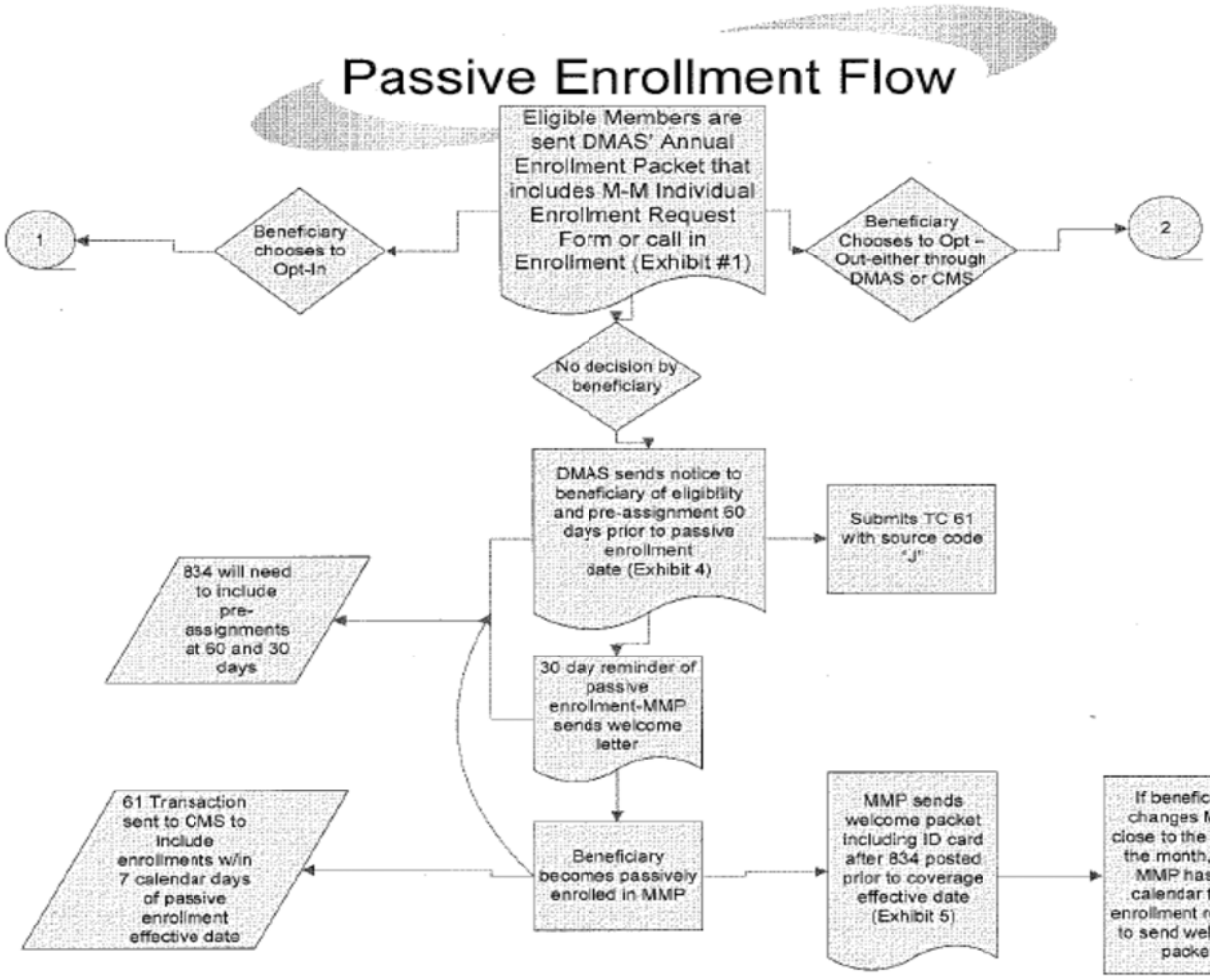


Note

Any disenrollment processed under these provisions Will always result in a change of enrollment to FFS Medicare & Medicaid, & auto-enrollment by CMS into a Medicare Prescription Drug Plan and LI NET transitional PDP during Any coverage gap.

Flow Diagram 7

Passive Enrollment Flow



Note

Medicare/Medicaid eligibility verification Done initially and each month thereafter For enrolled and newly eligible only-not Those who have opted out

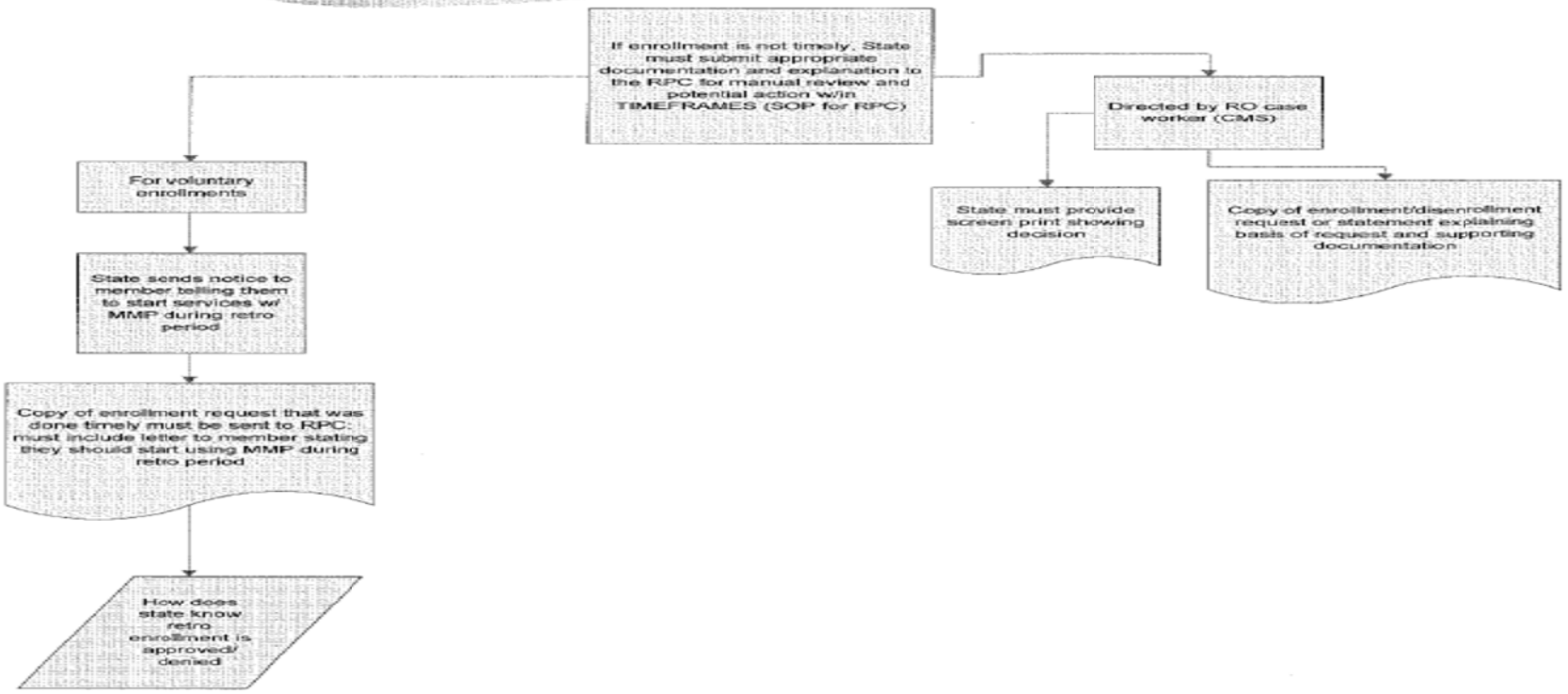
Note

Can opt-out or change MMPs at any time but Disenrollments are implemented at the end of the month

7/12/2013

Flow Diagram 8

Retro Enrollment Flow



7/8/2013

ATTACHMENT XXII – CERTIFICATION OF COMPLIANCE

With Prohibition Of Political Contributions And Gifts During The Procurement Process

For contracts with a stated or expected value of $5 million or more except those awarded as the result of competitive sealed bidding

I, _____, a representative of _____,
Please Print Name *Name of Bidder/Offeror*

am submitting a bid/proposal to _____ in response to
Name of Agency/Institution

_____, a solicitation where stated or expected contract value is
Solicitation/Contract #

$5 million or more which is being solicited by a method of procurement other than competitive sealed

bidding as defined in § 2.2-4301 of the Code of Virginia.

I hereby certify the following statements to be true with respect to the provisions of §2.2-4376.1 of the Code of Virginia. I further state that I have the authority to make the following representation on behalf of myself and the business entity:

1. The bidder/Offeror will not knowingly provide a contribution, gift, or other item with a value greater than $50 or make an express or implied promise to make such a contribution or gift to the Governor, his political action committee, or the Governor's Secretaries, if the Secretary is responsible to the Governor for an agency with jurisdiction over the matters at issue, during the period between the submission of the bid/proposal and the award of the contract.

2. No individual who is an officer or director of the bidder/Offeror, will knowingly provide a contribution, gift, or other item with a value greater than $50 or make an express or implied promise to make such a contribution or gift to the Governor, his political action committee, or the Governor's Secretaries, if the Secretary is responsible to the Governor for an agency with jurisdiction over the matters at issue, during the period between the submission of the bid/proposal and the award of the contract.

3. I understand that any person who violates § 2.2-4376.1 of the Code of Virginia will be subject to a civil penalty of $500 or up to two times the amount of the contribution or gift, whichever is greater.

_____
Signature

_____
Title

_____
Date

To Be Completed By Offeror and Returned With Your Technical Proposal

ATTACHMENT XXIII – PROPRIETARY/CONFIDENTIAL INFORMATION FORM

Trade secrets or proprietary information submitted by an Offeror shall not be subject to public disclosure under the Virginia Freedom of Information Act; however, the Offeror must invoke the protections of § 2.2-4342F of the *Code of Virginia*, in writing, either before or at the time the data or other material is submitted. The written notice must specifically identify the data or materials to be protected including the section of the proposal in which it is contained and the page numbers, and states the reasons why protection is necessary. The proprietary or trade secret material submitted must be identified by some distinct method such as highlighting or underlining and must include only the specific words, figures, or paragraphs that constitute trade secret or proprietary information. In addition, a summary of such information shall be submitted on this form. The classification of an entire proposal document, line item prices, and/or total proposal prices as proprietary or trade secrets is not acceptable. If, after being given reasonable time, the Offeror refuses to withdraw such a classification designation, the proposal may be scored lower or eliminated from further consideration.

Name of Firm/Offeror:_____, invokes the protections of § 2.2-4342F of the Code of Virginia for the following portions of my proposal submitted on _____.

Date

Signature:_____ Title:_____

DATA/MATERIAL TO BE PROTECTED	SECTION NO., & PAGE NO.	REASON WHY PROTECTION IS NECESSARY

To Be Completed by Offeror and Returned with Your Technical Proposal

ATTACHMENT XXIV – STATE CORPORATION COMMISSION FORM

Virginia State Corporation Commission (SCC) registration information. The Offeror:

□ is a corporation or other business entity with the following SCC identification number: _____ **-OR-**

□ is not a corporation, limited liability company, limited partnership, registered limited liability partnership, or business trust **-OR-**

□ is an out-of-state business entity that does not regularly and continuously maintain as part of its ordinary and customary business any employees, agents, offices, facilities, or inventories in Virginia (not counting any employees or agents in Virginia who merely solicit orders that require acceptance outside Virginia before they become contracts, and not counting any incidental presence of the Offeror in Virginia that is needed in order to assemble, maintain, and repair goods in accordance with the contracts by which such goods were sold and shipped into Virginia from Offeror's out-of-state location) **-OR-**

□ is an out-of-state business entity that is including with this proposal an opinion of legal counsel which accurately and completely discloses the undersigned Offeror's current contacts with Virginia and describes why those contacts do not constitute the transaction of business in Virginia within the meaning of § 13.1-757 or other similar provisions in Titles 13.1 or 50 of the Code of Virginia.

NOTE >> Check the following box if you have not completed any of the foregoing options but currently have pending before the SCC an application for authority to transact business in the Commonwealth of Virginia and wish to be considered for a waiver to allow you to submit the SCC identification number after the due date for proposals (the Commonwealth reserves the right to determine in its sole discretion whether to allow such waiver): □

To Be Completed by Offeror and Returned with Your Technical Proposal

_____
Signature

_____
Title

_____

ATTACHMENT XXV - THE 2014 APPROPRIATIONS ACT

2014 Acts of Assembly, Chapter 3, Item 301 OO

OO. The Department of Medical Assistance Services shall seek federal authority through the necessary waiver(s) and/or State Plan authorization under Titles XIX and XXI of the Social Security Act to expand principles of care coordination to all geographic areas, populations, and services under programs administered by the department. The expansion of care coordination shall be based on the principles of shared financial risk such as shared savings, performance benchmarks or risk and improving the value of care delivered by measuring outcomes, enhancing quality, and monitoring expenditures. The department shall engage stakeholders, including beneficiaries, advocates, providers, and health plans, during the development and implementation of the care coordination projects. Implementation shall include specific requirements for data collection to ensure the ability to monitor utilization, quality of care, outcomes, costs, and cost savings. The department shall report by November 1 of each year to the Governor and the Chairmen of the House Appropriations and Senate Finance Committees detailing implementation progress including, but not limited to, the number of individuals enrolled in care coordination, the geographic areas, populations and services affected and cost savings achieved. Unless otherwise delineated, the department shall have authority to implement necessary changes upon federal approval and prior to the completion of any regulatory process undertaken in order to effect such change. The intent of this Item may be achieved through several steps, including, but not limited to, the following:

a. In fulfillment of this item, the department may seek federal authority to implement a care coordination program for Elderly or Disabled with Consumer Direction (EDCD) waiver participants effective October 1, 2011. This service would be provided to adult EDCD waiver participants on a mandatory basis. The department shall have authority to promulgate emergency regulations to implement this amendment within 280 days or less from the enactment of this act.

b. In fulfillment of this item, the department may seek federal authority through amendments to the State Plan under Title XIX of the Social Security Act, and any necessary waivers, to allow individuals enrolled in Home and Community Based Care (HCBC) waivers to also be enrolled in contracted Medallion II managed care organizations for the purposes of receiving acute and medical care services. The department shall have authority to promulgate emergency regulations to implement this amendment within 280 days or less from the enactment of this act.

c. In fulfillment of this item, the department and the Department of Behavioral Health and Developmental Services, in collaboration with the Community Services Boards and in consultation with appropriate stakeholders, shall develop a blueprint for the development and implementation of a care coordination model for individuals in need of behavioral health services not currently provided through a managed care organization. The overall goal of the project is to improve the value of behavioral health services purchased by the Commonwealth of Virginia without compromising access to behavioral health services for vulnerable populations. Targeted case management services will continue to be the responsibility of the Community Services Boards. The blueprint shall: (i) describe the steps for development and implementation of the program model(s) including funding, populations served, services provided, timeframe for program implementation, and education of clients and providers; (ii) set the criteria for medical necessity for community mental health rehabilitation services; and (iii) include the following principles:

1. Improves value so that there is better access to care while improving equity.

2. Engages consumers as informed and responsible partners from enrollment to care delivery.

3. Provides consumer protections with respect to choice of providers and plans of care.

4. Improves satisfaction among providers and provides technical assistance and incentives for quality improvement.

5. Improves satisfaction among consumers by including consumer representatives on provider panels for the development of policy and planning decisions.

6. Improves quality, individual safety, health outcomes, and efficiency.

7. Develops direct linkages between medical and behavioral services in order to make it easier for consumers to obtain timely access to care and services, which could include up to full integration.

8. Builds upon current best practices in the delivery of behavioral health services.

9. Accounts for local circumstances and reflects familiarity with the community where services are provided.

10. Develops service capacity and a payment system that reduces the need for involuntary commitments and prevents default (or diversion) to state hospitals.

11. Reduces and improves the interface of vulnerable populations with local law enforcement, courts, jails, and detention centers.

12. Supports the responsibilities defined in the Code of Virginia relating to Community Services Boards and Behavioral Health Authorities.

13. Promotes availability of access to vital supports such as housing and supported employment.

14. Achieves cost savings through decreasing avoidable episodes of care and hospitalizations, strengthening the discharge planning process, improving adherence to medication regimens, and utilizing community alternatives to hospitalizations and institutionalization.

15. Simplifies the administration of acute psychiatric, community mental health rehabilitation, and medical health services for the coordinating entity, providers, and consumers.

16. Requires standardized data collection, outcome measures, customer satisfaction surveys, and reports to track costs, utilization of services, and outcomes. Performance data should be explicit, benchmarked, standardized, publicly available, and validated.

17. Provides actionable data and feedback to providers.

18. In accordance with federal and state regulations, includes provisions for effective and timely grievances and appeals for consumers.

d. The department may seek the necessary waiver(s) and/or State Plan authorization under Titles XIX and XXI of the Social Security Act to develop and implement a care coordination model, that is consistent with the principles in Paragraph e, for individuals in need of behavioral health services not currently provided through managed care to be effective July 1, 2012. This model may be applied to individuals on a mandatory basis. The

department shall have authority to promulgate emergency regulations to implement this amendment within 280 days or less from the enactment date of this act.

e.1. The department may seek the necessary waiver(s) and/or State Plan authorization under Title XIX of the Social Security Act to develop and implement a care coordination model for individuals dually eligible for services under both Medicare and Medicaid. The Director of the Department of Medical Assistance Services, in consultation with the Secretary of Health and Human Resources, shall establish a stakeholder advisory committee to support implementation of dual-eligible care coordination systems. The advisory committee shall support the dual-eligible initiatives by identifying care coordination and quality improvement priorities, assisting in securing analytic and care management support resources from federal, private and other sources and helping design and communicate performance reports. The advisory committee shall include representation from health systems, health plans, long-term care providers, health policy researchers, physicians, and others with expertise in serving the aged, blind, and disabled, and dual-eligible populations. The department shall have authority to implement necessary changes upon federal approval and prior to the completion of any regulatory process undertaken in order to effect such change.

2. There is hereby created in the state treasury a special nonreverting fund to be known as the Commonwealth Coordinated Care Pay for Performance Fund, hereafter referred to as the "fund." The fund shall be established on the books of the Comptroller and any moneys remaining in the Fund at the end of each fiscal year shall not revert to the general fund but shall remain in the fund. Moneys deposited to the fund shall be used solely for bonus payments to managed care organizations participating in the Commonwealth Coordinated Care program that meet the performance criteria of the pay for performance program specified in paragraph OO.e.1.

3. The department is authorized to implement a quality withhold program in the context of the initiative implemented pursuant to OO.e.1. Quality withhold funds, withheld from health plan capitation payments, shall be deposited in the fund created pursuant to OO.e.2. At the time and in the amounts determined by DMAS and Centers for Medicare and Medicaid Services, DMAS shall be authorized to make payments from the fund to health plans that meet quality performance measures stipulated in the Memorandum of Understanding and contract with health plans entered into pursuant to OO.e.1. Funds deposited in the fund may be used only for such payments.

4. The Department of Planning and Budget in collaboration with the Department of Medical Assistance services shall transfer general fund appropriation withheld from funds set aside in connection with a pay for performance program related to the dual eligible initiative pursuant to paragraph OO.e.1., to the fund.

ATTACHMENT XXVI
Call Volume and Enrollment Data for Medallion 3.0 & CCC Programs

Medallion 3.0	Incoming Calls	Total Calls Answered	Outgoing Calls	Answered + Outgoing Calls	Abandon <15 Sec	Abandon >15 Sec	Abandon Rate	Total Abandon	Average Wait Time (seconds)	Average Talk Time (seconds)	Average Abandon Time (seconds)	VA Agents Logged In	XX Agents Logged In	Enrollment
Jul-11	10,603	9,596	510	10,106	137	870	8.21%	1,007	49	353	91	8.7	6.6	531,679
Aug-11	10,758	9,779	648	10,427	113	866	8.05%	979	50	359	102	8.3	6.3	531,150
Sep-11	10,890	9,956	636	10,592	103	831	7.63%	934	53	347	102	7.9	6.5	531,417
Oct-11	9,373	8,439	756	9,195	109	825	8.80%	934	60	351	98	7.4	5.3	529,535
Nov-11	10,399	9,530	1278	10,808	108	761	7.32%	869	55	356	94	11.1	4.9	531,681
Dec-11	15,934	13,844	645	14,489	197	1,893	11.88%	2,090	81	397	147	13.8	5	535,238
Jan-12	17,962	15,439	1343	16,782	360	2,163	12.04%	2,523	91	364	126	12.6	6.4	566,153
Feb-12	14,026	12,815	818	13,633	137	1,074	7.66%	1,211	56	407	111	10.1	9.1	569,133
Mar-12	13,117	11,935	922	12,857	138	1,044	7.96%	1,182	57	401	93	9.8	9.9	567,871
Apr-12	10,846	9,985	484	10,469	69	792	7.30%	861	44	370	115	11.3	8.1	569,301
May-12	13,238	12,185	1514	13,699	136	917	6.93%	1,053	44	374	89	10.6	7.4	571,210
Jun-12	21,756	17,506	645	18,151	404	3,846	17.68%	4,250	118	404	186	13.5	9.6	573,759
Jul-12	18,299	16,026	783	16,809	234	2,039	11.14%	2,273	71	347	110	13.2	9.1	621,016
Aug-12	12,428	11,442	961	12,403	114	872	7.02%	986	40	357	87	11.4	7.8	620,557
Sep-12	9,728	9,001	335	9,336	79	648	6.66%	727	38	358	81	11.3	8.9	620,787
Oct-12	9,991	9,302	435	9,737	73	616	6.17%	689	35	345	87	10.7	10.1	624,578
Nov-12	8,369	7,761	357	8,118	77	531	6.34%	608	35	361	85	11.6	10.4	626,325
Dec-12	7,729	7,111	411	7,522	68	550	7.12%	618	41	379	98	10.3	10.6	632,364
Jan-13	10,412	9,679	480	10,159	94	639	6.14%	733	39	359	86	11.5	9.6	634,564
Feb-13	9,742	8,994	407	9,401	62	686	7.04%	748	42	381	88	11.3	9.4	637,182
Mar-13	9,390	8,782	407	9,189	71	537	5.72%	608	36	394	89	11.9	7.4	635,740
Apr-13	8,700	8,195	218	8,413	53	452	5.20%	505	28	364	111	11.3	7.7	635,390
May-13	10,457	9,668	305	9,973	78	711	6.80%	789	38	398	100	11.5	8.7	634,713
Jun-13	8,444	7,943	177	8,120	53	448	5.31%	501	37	383	72	10.5	9.4	635,467
Jul-13	11,493	10,505	399	10,904	126	862	7.50%	988	45	351	92	9.4	7.6	634,435
Aug-13	9,929	9,112	349	9,461	90	727	7.32%	817	50	356	94	8.7	6.9	631,626
Sep-13	9,901	9,025	335	9,360	80	796	8.04%	876	53	330	107	8.9	4.3	630,003
Oct-13	10,951	10,082	786	10,868	7	862	7.87%	869	68	310	112	9.1	4.5	629,647
Nov-13	7,795	7,258	429	7,687	24	513	6.58%	537	52	302	117	9.3	5.5	637,081
Dec-13	10,271	9,142	558	9,700	102	1027	10.00%	1129	60	318	164	12.3	3.2	640,535
Jan-14	9,867	9,002	331	9,333	98	767	7.77%	865	47	335	89	11	3.4	637,624
Feb-14	11,262	10,021	1118	11,139	134	1107	9.83%	1241	58	343	204	15.4	3.2	635,925
Mar-14	13,320	12,188	480	12,668	114	1018	7.64%	1132	49	343	101	11.2	5.5	636,161
Apr-14	12,963	12,325	210	12,535	80	558	4.30%	638	27	245	72	12.2	5.2	632,935
May-14	16,050	14,231	677	14,908	175	1644	10.24%	1819	75	344	123	12	5.6	638,153
Jun-14	13,070	11,643	299	11,942	110	1317	10.08%	1427	66	318	207	10.2	3.3	645,017
Jul-14	17,157	15,120	1339	16,459										644,720
Aug-14	17,384	14,908	1342	16,250										644,263
Sep-14	21,794	15,158	398	15,556										659,385
Oct-14	21,506	16,335	308	16,643										664,603
Nov-14	16,645	12,391	278	12,669										668,514
Dec-14	18,406	14,267	1048	15,315										674,020
Jan-15	15,827	15,187	1099	16,286										672,937

Medallion 3.0	Incoming Calls	Total Calls Answered	Outgoing Calls	Answered + Outgoing Calls	Abandon <15 Sec	Abandon >15 Sec	Abandon Rate	Total Abandon	Average Wait Time (seconds)	Average Talk Time (seconds)	Average Abandon Time (seconds)	VA Agents Logged In	XX Agents Logged In	Enrollment
Feb-15	15,200	14,648	2057	16,705										674,661
Mar-15	16,582	16,161	2753	18,914										681,456
Apr-15	17,967	15,310	680	15,991										687,697
May-15	18,233	15,525	685	16,210										692,892
Jun-15	18,394	15,652	685	16,337										694,099
Jul-15	18,556	15,779	685	16,465										695,305
Aug-15	18,719	15,907	686	16,592										696,512
Sep-15	18,882	16,035	686	16,721										697,719
Oct-15	19,045	16,163	686	16,849										698,926
Nov-15	19,209	16,291	687	16,978										700,132
Dec-15	19,373	16,420	687	17,107										701,339
Jan-16	19,538	16,549	687	17,236										702,546
Feb-16	19,703	16,679	687	17,366										703,752
Mar-16	19,869	16,809	688	17,496										704,959
Apr-16	20,035	16,939	688	17,627										706,166
May-16	20,202	17,070	688	17,758										707,372
Jun-16	20,369	17,201	689	17,889										708,579
Jul-16	20,536	17,332	689	18,021										709,786
Aug-16	20,704	17,463	689	18,153										710,993
Sep-16	20,872	17,595	689	18,285										712,199
Oct-16	21,041	17,728	690	18,417										713,406
Nov-16	21,211	17,860	690	18,550										714,613
Dec-16	21,380	17,993	690	18,684										715,819
Jan-17	21,550	18,127	691	18,817										717,026
Feb-17	21,721	18,260	691	18,951										718,233
Mar-17	21,892	18,394	691	19,086										719,439
Apr-17	22,064	18,529	691	19,220										720,646
May-17	22,236	18,664	692	19,355										721,853
Jun-17	22,408	18,799	692	19,491										723,060
Jul-17	22,581	18,934	692	19,626										724,266
Aug-17	22,754	19,070	692	19,762										725,473
Sep-17	22,928	19,206	693	19,899										726,680
Oct-17	23,102	19,343	693	20,035										727,886
Nov-17	23,277	19,479	693	20,172										729,093
Dec-17	23,452	19,617	693	20,310										730,300
Jan-18	23,628	19,754	693	20,448										731,506
Feb-18	23,804	19,892	694	20,586										732,713
Mar-18	23,980	20,030	694	20,724										733,920
Apr-18	24,157	20,169	694	20,863										735,127
May-18	24,335	20,308	694	21,002										736,333
Jun-18	24,512	20,447	695	21,141										737,540
Jul-18	24,691	20,586	695	21,281										738,747

Medallion 3.0	Incoming Calls	Total Calls Answered	Outgoing Calls	Answered + Outgoing Calls	Abandon <15 Sec	Abandon >15 Sec	Abandon Rate	Total Abandon	Average Wait Time (seconds)	Average Talk Time (seconds)	Average Abandon Time (seconds)	VA Agents Logged In	XX Agents Logged In	Enrollment
Aug-18	24,869	20,726	695	21,421										739,953
Sep-18	25,049	20,867	695	21,562										741,160
Oct-18	25,228	21,007	695	21,703										742,367
Nov-18	25,408	21,148	696	21,844										743,573
Dec-18	25,589	21,290	696	21,985										744,780
SFY 2012	158,902	141,009	10,199	151,208	2,011	15,882	9.99%	17,893	67	377	129	10.4	7.1	550,677
SFY 2013	123,689	113,904	5,276	119,180	1,056	8,729	7.06%	9,785	42	367	94	11.4	9.1	629,890
SFY 2014	136,872	124,534	5,971	130,505	1,140	11,198	8.18%	12,338	55	324	131	10.8	4.9	635,762
SFY 2015	215,096	180,663	12,672	193,335										671,604
SFY 2016	233,501	197,841	8,243	206,084										701,942
SFY 2017	257,616	216,745	8,284	225,029										716,423
SFY 2018	282,510	236,248	8,320	244,568										730,903

Commonwealth Coordinated Care	Incoming Calls	Total Calls Answered	Outgoing Calls	Answered + Outgoing Calls	Average Talk Time (seconds)
Jul-11					
Aug-11					
Sep-11					
Oct-11					
Nov-11					
Dec-11					
Jan-12					
Feb-12					
Mar-12					
Apr-12					
May-12					
Jun-12					
Jul-12					
Aug-12					
Sep-12					
Oct-12					
Nov-12					
Dec-12					
Jan-13					
Feb-13					
Mar-13					
Apr-13					
May-13					
Jun-13					
Jul-13					
Aug-13					
Sep-13					
Oct-13					
Nov-13					
Dec-13					
Jan-14					
Feb-14					

Enrollment

Commonwealth Coordinated Care	Incoming Calls	Total Calls Answered	Outgoing Calls	Answered + Outgoing Calls	Average Talk Time (seconds)	Enrollment
Mar-14	5,083	4,926	440	5,366	433	
Apr-14	4,039	3,909	56	3,965	337	
May-14	10,222	9,037	438	9,475	380	
Jun-14	9,065	8,167	230	8,397	367	
Jul-14	12,018	10,089	1008	11,097	378	
Aug-14	12,069	11,420	730	12,150	358	
Sep-14	11,320	10,723	572	11,295	362	
Oct-14	8,108	7,726	369	8,095	387	
Nov-14	4,777	4,570	130	4,700	376	
Dec-14	4,848	4,689	570	5,259	383	
Jan-15	4,066	3,994	505	4,499	361	27,246
Feb-15	2,948	2,932	718	3,650	385	27,268
Mar-15	4,229	4,115	415	4,530		27,291
Apr-15	4,231	4,117	417	4,534		27,314
May-15	4,233	4,119	419	4,538		27,337
Jun-15	4,235	4,121	421	4,542		27,359
Jul-15	4,237	4,123	423	4,546		27,382
Aug-15	4,239	4,125	425	4,550		27,405
Sep-15	4,241	4,127	427	4,554		27,428
Oct-15	4,243	4,129	429	4,558		27,451
Nov-15	4,245	4,131	431	4,562		27,474
Dec-15	4,248	4,133	433	4,566		27,496
Jan-16	4,250	4,135	435	4,570		27,519
Feb-16	4,252	4,137	436	4,573		27,542
Mar-16	4,254	4,139	438	4,577		27,565
Apr-16	4,256	4,141	440	4,581		27,588
May-16	4,258	4,143	442	4,585		27,611
Jun-16	4,260	4,145	444	4,589		27,634
Jul-16	4,262	4,147	446	4,593		27,657
Aug-16	4,264	4,149	448	4,597		27,680
Sep-16	4,266	4,151	450	4,601		27,703

Commonwealth Coordinated Care	Incoming Calls	Total Calls Answered	Outgoing Calls	Answered + Outgoing Calls	Average Talk Time (seconds)		Enrollment
Oct-16	4,269	4,153	452	4,605			27,726
Nov-16	4,271	4,155	454	4,609			27,750
Dec-16	4,273	4,157	456	4,613			27,773
Jan-17	4,275	4,159	458	4,617			27,796
Feb-17	4,277	4,161	460	4,621			27,819
Mar-17	4,279	4,163	462	4,625			27,842
Apr-17	4,279	4,164	463	4,626			27,865
May-17	4,282	4,166	465	4,630			27,889
Jun-17	4,284	4,168	467	4,634			27,912
Jul-17	4,286	4,170	469	4,638			27,935
Aug-17	4,288	4,172	471	4,642			27,958
Sep-17	4,290	4,173	472	4,646			27,982
Oct-17	4,292	4,175	474	4,650			28,005
Nov-17	4,294	4,177	476	4,654			28,028
Dec-17	4,296	4,179	478	4,658			28,052
Jan-18	4,298	4,181	480	4,662			28,075
Feb-18	4,300	4,183	482	4,666			28,098
Mar-18	4,302	4,185	484	4,670			28,122
Apr-18	4,304	4,187	486	4,674			28,145
May-18	4,307	4,189	488	4,678			28,169
Jun-18	4,309	4,191	490	4,682			28,192
Jul-18	4,311	4,193	492	4,686			28,216
Aug-18	4,313	4,195	494	4,690			28,239
Sep-18	4,315	4,197	496	4,694			28,263
Oct-18	4,317	4,199	498	4,698			28,286
Nov-18	4,319	4,201	500	4,702			28,310
Dec-18	4,321	4,203	502	4,706			28,333
SFY 2012							
SFY 2013							
SFY 2014	28,409	26,039	1,164	27,203	379		
SFY 2015	77,082	72,616	6,275	78,890	374		

Commonwealth Coordinated Care	Incoming Calls	Total Calls Answered	Outgoing Calls	Answered + Outgoing Calls	Average Talk Time (seconds)		Enrollment
SFY 2016	50,983	49,609	5,204	54,814			
SFY 2017	51,280	49,892	5,480	55,373			
SFY 2018	51,565	50,164	5,752	55,915			